DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WALTER RUSSELL ALLNUTT 9:22 A M AUGUST 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1**X** M 2□ F 217-48-8226 Director Oct. 14 1920 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Potomac 1 ☐Yes 2 X No Director Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10917 Burbank Drive 20854 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black White etc. 1 Mayes 2 No If Yes, Give Year or Dates: Unknown 1X Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No à Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nal any injury or other traumatic event, the Mental once. Elementary/Secondary (0-12) College (1-4or 5+) School System Janitor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Allnutt Lena Duvall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Potomac, Carolyn D. Pare / Niece 10917 Burbank Drive, Mđ. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Laytonsville Cem. 9/5/08 Laytonsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature f Fungral Service License 22. Name and Address of Facility
Muriel H. Barber Funeral Home m - 00470 P. O. Box 5038, Laytonsville, Md. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence f): Examiner Sequentially list conditions Examiner Diss to (or as a consequency of) than, leading to minedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performe certificate ! 1 ☐Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation I hours after death. uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Direst completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number TUMPI NO

within 72 hours after

the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

or Attending Physician;

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Drive Olney mb 20832

			State of Maryland / Dep 1- State amend #5 Per FH G883 9/26/20	artment of Health and N 8 IH Prificate of Death	Mental Hygid	ene 1. No. 2008 30003
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
*	/Medic	cal		Lat. Cit. Toward and Control	September	
	Examin	ner	SOUTHERN MARYLAND HOSPITAL CENTER	4b. City, Town, or Location of Death CLINTON		4c. County of Death  PRINCE GEOREE S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Y	
	Director		246-16-5063 1	Months Says Hours Min.	8/4/1918	Wilson Co. NC
Vand	Mon		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Ma	liffed	ctor	Maryland Prince George's Fort Was	hington		1★TYes 2□No
ŧ.	or 28	<b>Funeral Director</b>	10e. Street and Number	10f. Zip Code	10g	J. Citizen of What Country?
eath v	15 23a	eral	9604 Traverse Way  11. Marital Status   12. Was Decedent Ever in U.S.   13.	20744		14. Race - American Indian,
o ffer d	r Item		1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
ING ZIZIS-UU36 be filed within 72 hours after death with the Marvland	Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	d by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Black
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and a	other vent,	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	
	Menta arked atic e	2	Henry Ellibee	Orabel1	McLaurin	
Var 12 sho	h and 7 is m traum			ing Address (Street and Number or Rui		
<b>a</b> , t	Healt tem 2 other			Raum Street, N.E.		shington, DC 20002 lc. Location - City or Town, State
Dell'III Delles	ent of nt: If if		1 2 Dullar 2 Defination 3 D Herioya Horn State	matory or other place)		uitland, Maryland
	Departm Importar any Injui		DINCOIN	Memorial : 9/11 2. Name and Address of Facility Por		
<u>a</u> <u>a</u>	<b>B E G</b>					lle, Maryland 20747
			23a. Parti. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	t, Approximate Interval Between Onset and Death
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	umonia		Onset and Death
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ecuted	nd transit	Examiner	Cause (Disease or injury that initiated events c			
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lires t	<u>5</u> 8	호	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
S se s	s peen s	lete	Atheroschoroki Cordina	iscular Disease	24a. Was an	24b. Were autopsy findings available
The la	# O I	Completed	-7.7	131 410, 13036	autopsy performe	prior to completion of cause of death?
ian:	ertifica ctor, p	0	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 h (Check only one)	ANo 1 □Yes 2 ANo
hysic	this ce	To B	examiner?  1 Yes 2 Hospital: 1 Hapatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	ome 5 Residence	ce 6 ☐ Other (Specify)
Ing P	After funera	ion:	27. Manner of Death 12 Hatural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 11 Injury	Work?	28d. Describe how	injury occurred
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the Hospital or Attending Physician: The law requires that the death certific	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occur	, and due to the cau red at the time, date	ise(s) and manner as stated. e and place, and due to the cause(s)
To the	within To the compl	Me	29b. Signature and title of certifier	29c. License number		I. Date signed (Month, Day, Year)
			I theles	P0037066		09-02-2008
14	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, U.Le.L.; 7. OPqiq5 e094, m.	Print) 618107 0 KON	Hon Hit!	1 Rood # 701 un 20145
	Stat	re.	31. Date filed (Month, Day, Year)  SFP 0 5 2008  32. Registrar's Signature	,	,,,,	
	Registra	al	SEL O O TODO COMPONENTA			

DHMH 17 Rev 1/2001

			1- For Amend Item 24a per Ver	land / Dep Ce	of rtificate of	lealth and I <b>dhb</b> <i>Death</i>	Mental Hyg F	giene 2 () () Reg. No.	18 30004
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ith	3. Time of Death
	/Medic		HELEN ELIZABETH ADAMS				SEPT.	4, 2008 Ye	07:28A M
	Examin	er	4a. Facility Name (If not institution, give street and number) CHESTER RIVER MANOR			r Location of Death	1	4c. County of E	Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day		Birthplace (State or Foreign
	Director		212-03-2875 1□M 2\(\text{M}\)F 96	5 Yrs.	Months Days	Hours Min.	10/20/1	1911	NJ
	land Sw		Usual Residence of Decedent  10a. State 10b. County 10c	. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f sh	tor	MD KENT	CHESTERT	OWN				1 X Yes 2 □ No
	th the	Director	10e. Street and Number		10f. Zip Code	<del></del>		10g. Citizen of Wha	t Country?
	s 23a		200 MORGNEC RD.		21620			USA	
"	ter de ritem instru	Funeral	11. Marital Status  12. Was Decedent Ever Armed Forces?  1 ☑ Yes 2 ☒ No	in U.S.   13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.
036	J within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 28a-f show the Modical Examinar must be rediffed at	Ď	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □Yes 2X No	Specify:		Specify:	WHITE
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od 2	othe ent,	Be C	17. Father's Name (First, Middle, Last)	BOOK	KEELEK	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	J/KLIAIL
/lar		70 B	PAUL N. ADAMS			RACHEL A	A. MAXWE	LL	
lar	2 sho n and ls ma		19a. Informant's Name/Relationship (Type. Print)		•			er, City or Town, Sta	te, Zip Code)
, e,	es 1 and 2 should b of Health and Meni (Item 27 is marked r other traumatic		BERTHA KIRCHER/SISTER  20a. Method of Disposition 2		OX 308 CH		N, MD 21	620 20c. Location - City	v or Town. State
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Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee					NAM FUNER	
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	Physician /Medical Examiner		resulting in death)  Due to (or a a cor	emin's.	Described of dyling of the second of the sec	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death Syycum
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	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my one)  1 Medical Examiner: On the basis of examiner and manner stated.	knowledge, deaf mination and/or ir	h occurred at the ti evestigation, in my o	me, date and place opinion, death occu	e, and due to the orred at the time, or	cause(s) and mannedate and place, and	er as stated. due to the cause(s)
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	4		I Junt flow is	<u>;</u>	1)01	217036		9/4/08	
_	ms		30. Name and address of person who completed cause of death Susan K. Ross M.P. 50	(Item 23a) (Type,	Print) Am Ar	e. Ole	Anton	9/4/08 Mil s	21620
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registr's S	any M	Species				

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	Physici		1. Decedent's Name (First, Middle, Last)  Leven Alber		Jr.			2. Date of Dea Month Septem		2ඊර්8	3. Time of 0	Death pM
	/Medio		4a. Facility Name (If not institution, give s 1204 Riverside Dr			4b. City, Town, or Salisbu			4c. Cour	nty of Death	0	
	Funeral Director		5. Social Security Number 217–24–6938  0. Sex 1 №  Usual Residence of Decedent	7. Age (In yrs. 79	ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birt Min. (Month, Da 8/22/1	h y, Year) 9 <b>29</b>	Cour	lace (State or try) yland	Foreign
	e Maryland Ba-f show tiffed at	Director	10a. State 10b. County  Maryland Wicomico		y, Town or Lo Salish					1	0d. Inside City	
	3a or 2	al Dire	10e. Street and Number 1204 Riverside D	rive		10f. Zip Code 2180	l		10g. Citizen o USA	f What Coun	try?	
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaninat must be notified at	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 <b>X</b> ]Yes 2∏No If Yes, Give <b>Army</b> Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 XNo	lispanic Origin an, Mexican, P Specify:	n? (Specify Yes or No Puerto Rican, etc.)	В	ace - Americ lack, White, c	etc.	
21215-0036	vithin 72 h ane. <b>than "natu</b>	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done of DO NOT use retired Trooper	durina most of	f working	16b. Kind of  State		·	
Maryland 2	Jid be filed v Aental Hygii rked other tic event, tr	To Be Co	17. Father's Name (First, Middle, Last) Leven Albert Ander	son Sr.	Deace	ricoper		Name (First, Middle, a Alice Pr	Maiden Surna		Lyrand	
, Mary	and 2 shouealth and N 27 is maler traumal		19a. Informant's Name/Relationship (Type Roland W. Morgan	,	1			or Rural Route Numberrace, Pri	-			53
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)			osition (Name of matory or other place k Cemeter		Date /5/08	20c. Location	•	wn, State	
Balt	permit Depart Import any inj		21. Signature of Funeral Service License	eurze (FSP	23	Holloway 501 Snow	Funera Hill F	al Home, P Rd., Salis	rofessi oury, N	ional 1D 218	Associa 04	ation
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deather cause on each line.  Due to (or as a consequence)	rcin			rdiac or respiratory a			Approximate Interval Betw Onset and D	veen
98760,	ficate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t								
O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	Ideath 3[	☐ Ectopic pregnanc☐ Other (specify) _	у		- 1	Date of delive	-	ear
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	he Hospit: in 24 hours he Funeral pletely filler	Medical C	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examir	siclan: To the best of my knoner: On the basis of examina and manner stated	wledge deat tion and/or in	th occurred at the timestigation, in my o	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) and date and plac	manner as se, and due to	tated. the cause(s)	
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	Sta	te	30. Name and address of person who co	. /	1 23a) (Type,	Print)	211011	51.,5	1:53	lory	MI	2

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Lalitaben Amin August 29, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 205 Shannon Court Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗗 F 84 154-74-2194 Director 1/26/1924 India Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinating to ust be inclified at 1 X Yes 2 □ No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Shannon Court 21804 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 □ Never Married 2 □ Married Asian/ Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify 3 X Widowed 4 ☐ Divorced Indian Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic permit. Pages 1 and 2 should be file
Department of Health and Mental Hy
Important: If Item 27 is marked oths
any injury or other transment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maganbhai Patel Kashiben Patel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yogesh Amin/son 205 Shannon Court, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Salisbury Crematory 9/1/08 Salisbury, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lightse <sup>2</sup> NaTion Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each jud Approximate Interval Between Onset and Death he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): Examiner Intenditial Sequentially list conditions, any leaf cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed the burial-transi Due to (or as a consequence of): Box 68760. physician Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. I signed by the a I be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed After this certificate 1 □ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1☐ Yes 2☐No Other: 4 Nursing Home Hesidence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division **Natural** 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY, MD. OGESH 614 EASTERN VOHLA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 4 2008 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician SEPTEMBER Day BILLIE BLAKESLEY LUELLA 2008 2 1:53 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗐 F Months Davs Hours 83 566~32-1042 July 3, 1925 California Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at Frederick Frederick Yes 2 No Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 21704 USA 5957 Quinn Orchard Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🐴No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced "natural" Completed of Health and Mental Hygiene.
If Item 27 is marked other than "nature or other traumatic event, Inc. Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 College (1-4or 5+) Elementary/Secondary (0-12) Medical Licensed Vocational Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dollie Fitzsimmons Robert G. Goodwin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21704 5957 Quinn Orchard Road, Frederick, Maryland Ralph Blakesley - husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-4-2008 Frederick, Maryland Stauffer Crematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Lause (Final disease condition resulting in death) 50 Physician /Medical Due to (or as a consequence of): **Examiner** 6000 Sequentially list conditions, if any, reading to infine right cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year 4 🔲 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy certificate 25 No 1 ☐ Yes director, Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this s after death.

I Director: After this id in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 24 hours Medical ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 2. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) W051610

DHMH 17 Rev 1/2001

State Registrar 21702

Frederic

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IANRU

SEP

31. Date filed (Month, Day, Year)

WQ.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 8:50 A IRENE E. BROOKS 2008 September02, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL & NURSING HO. CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F Months **Director** Chaple, E.C. /12/1938 577**–**50–0895 70 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director Maryland Prince George's Suitland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20746 3940 Bexley Place # 411 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black \$ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: if item 27 is marked other the any Injury or other traumatic event, Iral any Diury or other traumatic event, Iral <u>Cleaning Service Provider</u> Private 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Dean Brooks William J. Brooks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3914 Essex Ct. Temple Hills, Maryland 20748 William Brooks Jr. / Brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify), 9/12/2008 | Suitland, Maryland Lincoln Memorial 21. Signat of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. WHO MO1885 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, onheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of) **Examiner** DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami HYPERTENSION burial-tra Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical CORONIC RENAL FAILURE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has tirector, page 2 s autopsy performed? 1 ☐Yes 2 No 1 ☐Yes 2 ₩ No 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 K No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hou To the Funer completely fil 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 9/4/2008 D 0062116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

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Meklit Workneh MD 77.05 Belle Point Drive, Bowie Maryland 20770

08-06733

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Michael A. Biddle 2008 30009 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day September 2, 2008 2232 hrs Medical Examiner Michael Α. Biddle 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Penninsula Regional Medical Center Salisbury If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 31 Davs Hours Country) DE 11-22-1976 Director 222-48-3461 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No DE Worcester Ocean City 28a-f show MD. with the Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12349 Salisbury RD. 21842 USA 23a 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married  $_2$  X white Yes Yes 2 X No specify: Specify If Yes, Give Year Widowed Divorced ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) event, the Medic d Exa Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 iii. Pages 1 and 2 should be filed within 72 harment of Health and Mental Hygiene. ortant: If item 27 is marked other than "y 72 Retail Sales 12 Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Moira Hume Be Robert Biddle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Salisbury RD. Ocean City, MD. 21842 Robert Biddle Baltimore, I permit. Pages I and Department of Healt 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Townsend, DE. Townsend Cemetery 9-6-2008 Other Specify Donation 5 gnature of Funeral Service DANIELS of FAUTCHISON Middletown, DE, 19709 North Broad St not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications that caused the death. Do **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed pue Physician/Medical  $\mathbf{x}$  AMENDED 10a per fh g884 10-21-08 vt UNPENDED attending physician or use as the burial Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Day Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy certificate has death? Yes 2 V No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 2 1 V Yes 28a. Date of Injury 28d. Describe how injury occurred After 28h. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Driver of auto involved in a collision Sep 2, 2008 2200 hrs Natural Yes 2 V No hours after death.
uneral Director:
ly filled in by the f Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Mt. Hermon Road and Berry Road, Parsonsburg, MD determined (Specify) Street Δ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only within 2 To the F 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b\_Signature and title of certifier O.C.M.E. September 3, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD.

DHMH 17 Rev 1/2001 **OCME 2006** 

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r's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:55 AM わとナイン Blayloc 2008 September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** niversity of Maryland Medical Lenker Bultimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Days MARYLANO 1 M 2 F 217-60-8019 **Director** Vitoher 31, 195 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Exactivity in cutting 1 and pulling of the present of the property. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Elkridge MD Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21075 7890 Mayfield Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No White ۵ 3 Widowed 4 XX ivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Mary E. Page James Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7890 Mayfield Ave, Elkridge, MD 21075 Michael Schmid1 (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X urial 2 Cremation 3 Removal from State Resurrection Cemetery Sept8, 2008 Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 21. Signature of Funeral Service Licens mo15 33 )am 6633 Old Alex Ferry Rd. Clinton, MD 20735 ~ 23a. Part1. Enter the disease or complibations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23d. Date of delivery 3 🔲 Ectopic pregnancy Day Month Year 5 Other (specify) Ö the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 2 1 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number kmber 2,2008 AU4176435 A 493

State Registrar

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31. Date filed (Month, Day, Year) SEP 0 5

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Himber, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University & Maryland Hospita 5 to hange Als Skala MA 22 South Green 34.

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DHMH 17 Rev 1/2001

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Buren Street,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2008 August 8:09 A M Agnes L. Barnett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16804 Village Dr. West Upper Marlboro Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay Dec 1 7) Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F Maryland 214-30-1015 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, I'm Medical Evant Inc. Figure 12. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director MarylandPrince George's Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 USA 16804 Village Dr. West Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: Black þ 3 □Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 7th 0 Housewife None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Butler Irene Belt မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peggy Barnett(Daughter) 16804 Village Dr. West Upper Marlboro, 3altimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b (Place of Disposition (Name of cemetery crematory of other place) permit. Pages Department of Important: If if any injury or c 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 9-8-08 Veteran Cemetery Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) WMName and Address of Facility One Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Xon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year signed by the a I be detached for 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>ک</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform certificate 2 2100 1 ∐Yes 2. NO of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 ★ ★ → ★ → Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled ir the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of c rtifie ompleted cause of death (Item 23a) (Type, Pring 31. Date filed (Month, Da n 3 2008 Day, State 0

DHMH 17 Rev 1/2001

Registrar

# Page Not Found

			State of Maryland / Dep.  1 - State Registrar  Ce	artment of Health and I rtificate of Death		ene 2008 30015
	Physici		Decedent's Name (First, Middle, Last)  Lois E. Cheek		2. Date of Death Month	Day Year 3 2008 5:30a M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)  16010 Excalibur Road Apt. D-008	4b. City, Town, or Location of Death		4c. County of Death Prince George's
I	Funeral Director		5. Social Security Number 219–34–9726 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 98 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 1)	year) 9. Birthplace (State or Foreign Country) North Carolina
	within 72 hours after death with the Maryland lene. than "natural", or Items 23a or 28a-f show ha Medical Exercition out the notified a	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince George's  Bowie			10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	23a or 2			10f. Zip Code 20716		g. Citizen of What Country?
036	urs after des al", or Items Exemination	by Funeral	If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
1215-0036	be filed within 72 hours after death with the Marylan tal Hygiene.  Id other than "natural", or Items 23a or 28a-f show event, I'm Medical Exam har out to notified a	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  11 Hor	edent's Usual Occupation c kind of work done during most of work DO NOT use retired)  nemaker		Own Home
z pui	be filed ntal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Ma Dell Watso	aiden Surname)
ary	hou mar mat	은	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ng Address (Street and Number or Ru	ral Route Number,	City or Town, State, Zip Code)
more,	Pages 1 and 2 s nent of Health ar int: If Item 27 is iry or other trau		20a. Method of Disposition  20b. Place of Disposition  20c. Place of Disposition  20c. Place of Disposition  20c. Place of Disposition  20c. Place of Disposition	Cox Avenue, Hyatts position (Name of matory or other place) coln Cemetery 9/	Date 20	Dc. Location - City or Town, State  Brentwood, MD
Balt	permit. Pages Department of Important: If I any injury or		21. Signature of Funeral Savy e Licensee	2. Name and Address of Facility Fo		
1	De executed / Medical rician and purial-transit purial-transit	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	ter the mode of dying, such as cardiac	or respiratory arres	Approximate Interval Between Onset and Death
O. Box 68/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  d.  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
cords, P.	quires that the signed by ald be detac	٥	Part II. Other significant continuous continuum to death but not resulting in the t	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Heco	: The law re cate has bee page 2 sho	Completed			24a. Was an autopsy perform 1 □ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
ı vıtal	nysician nis certifi i director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Othory	ith (Check only one) iome 5 Resider	) nce 6  □Other (Specify)
DIVISION OF	ttending Pi death. :tor: After ti r the funeral	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not be determined	Work? M 1 □Yes 2 □No	28f Location (Str	v injury occurred set and Number or Rural Route Number,
2	ortal or A urs after eral Direc		4 Homicide determined building, etc. (Specify)		City or Town,	State)
	the Hosi nin 24 ho the Fund npletely i	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea   Check only one)  Medical Examiner: Of the basis of examination and/or in   and manner stated.	nvestigation, in my opinion, death occu	irred at the time, da	te and place, and due to the cause(s)
	vitt To To	2	29b. Signature and title of certified	29c. License number 5 8 28 9 (M	1	d. Date signed (Month, Day, Year) $9-3\cdot \circ \delta$
,	(4)		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	4D 20716	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 5 2008  SEP 0 5 2008			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	dwell State of N	Maryland / Departmen Certificate	t of Health and Mental Hy e of Death	rgiene Reg. No.	2008 30016			
	1. Decedent's Name (First, Middle,Last) Eula Bernadette C	aldwell		2. Date of Death  Month Day  September 10, 2008	3. Time of Death 1435 hrs			
	4a. Facility Name (if not institution, give stre 13305 Finsbury Ct. Apt #8	et and number)	4b. City, Town, or Location of Death  Laurel	Prince	ty of Death . e George's			
Funeral Director	5. Social Security Number 6. Sex 491–73–7605 1 M	7. Age (In yrs. last birthda 43	y) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	1065 5				
ow any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits 1 X Yes 2 No			
the Maryland as or 28a-f she tified at once	MD Prince Geo  10e. Street and Number	rges Laurel	10f. Zip Code	10g. Citizen of	What Country?			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	13305 Finsbury Ct.  11. Marital Status  1 X Never Married 2 Married		20708 . Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) W	ace - American Indian, Black, hite, etc.			
72 hours after on "natural", o	3 Widowed 4 Divorced If Ye or D  15. Decedent's Education (Specify only hid  Elementary/Secondary (0-12)	s, Give Year ates: phest grade completed) 16a. Dec	Yes 2X No specify: edent's Usual Occupation (Give kind of wing most of working life. DO NOT use retired.)	vork done 16b. Kind of	fy: Black Business/Industry			
5-0036 led within 7 Hygiene. other than the Medica	17. Father's Name (First, Middle, Last)		edit Consulant	Priv (First, Middle, Maiden Surna	ate Industry			
1215. Id be filed fental Hy narked of event, the	Donald Caldwell, J  19a. Informant's Name/Relationship (Type,		Betty .  lailing Address (Street and Number or F	Adam				
MD 21 dd 2 should ulth and Me m 27 is ma aumatic ev	Donald Caldwell/Bro	ther 500	Brooklyn Ave. Kar	sas City,MO	64124			
MOFE, Pages I an tent of Hea tunt: If iten or other fr:	20a. Method of Disposition  1 X Burial 2 Cremation 3 R  4 Donation 5 Other Specify:	emoval from State crematory	isposition (Name of cemetery, or other place)  y Cemetery Sept	.16.2008 Kans	on - City or Town, State			
Balti permit. Departin Importi	21. Signature of Funeral Service Licensee	278	22. Name and Address of Facility La 3831 Georgia Ave.	tney's Funera N.W. Wash.,	1 Home D.C. 20011			
Physician /Medical xaminer www.	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ie.	cosclerotic cardiov		Between Onset and			
iO, e be executed ysician and burial - transit	d.		E, g884 10/10/08 TI	Ĭ				
lox 6876 (eath certificate a attending phy for use as the I		cc. If yes, outcome of pregnancy Live birth Pregnant at time of death Unknown	Fetal death 3 Ectopic pregna Other (Specify)	23d. Dat	e of delivery h Day Year			
Is, P.O. Be quires that the deen signed by the labeled detached feed by Phy	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	1 Yes 2 ✔ No	ontribute to the cause of death?  3 Probably 4 Unknown  4b. Were autopsy findings available			
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by Funeral director, page 2 should be detachon: To Be Completed by Plon: To Be Completed by Pl	25. Was case referred to medical		26.Place of Death (Check	autopsy performed? 1 ✔ Yes 2 No	prior to completion of cause of death?  1 Yes 2 No			
Vital hysician: this certial director	examiner? 1 ✓ Yes 2 No	tal: 1 Inpatient 2 ER/Outp	I Dubana	ng Home 5 Residence	6 Other: Scene			
Sion of Vitending Ph death. extor: After t yy the funeral	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day,Year)	28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury oc	ccurred			
Division of a baptist or attending Pheurs after death, neural Director. After the filled in by the funeral Certification: Tecturing or a certification of the funeral or a certification or a certification.	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm (Specify)	, street, factory, office building, etc.	28f. Location (Street and No or Town, State)	umber or Rural Route Number, City			
Dit To the Hospitat or within 24 hours at to the Funeral I completely filled	one) 2 ✓ Medical Examiner:On	To the best of my knowledge, death the basis of examination and/or inversance stated.	occurred at the time, date and place, and stigation, in my opinion, death occurred a	d due to the cause(s) and man at the time, date and place, a	nner as stated. nd due to the cause(s)			
F * F * O	29b. Signature and title of certifier	egma	29c. License number O.C.M.E.		signed (Month, Day, Year) ber 11, 2008			
	•	stant Medical Examiner	111 Penn Street, Baltimore, M	D 21201				
State Registrar	31. Date filed (Month Day Year) 2008	32 Registrar's Signature	nantes					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Helen Nora Chapman September 3, 2008 12:00A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death La Plata Center La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□M 2\ F 579-26-5994 September 13,1925 WashingtonDC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 Garner Ave. 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZÃNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur Irving Anderson Helen Cecelia Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Burch/Niece 320 Garner Ave. Waldorf MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 9/5/2008 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signatupe of Funeral Service Licensee ZAREHART-ECHOLS' FUNERAL HOME, P.A. and 211 St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEHRT FAILURE Due to (or as a consequence of): PERTENSION TRIAL FIBRIALATION Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

physicien and the burial-transit

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or Attending Physician: The law requires that the death certificate be executed

certificete has

i after death.
I Director: Aft

within 24 hours a

completely

Box 68760

P.O.

Division of Vital Records.

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

iteme 23a

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Hygiene.

le marked o

item 27

permit. Pages 1 Department of H Importent: if ite any injury or ot ance.

other

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Completed by Funeral

Be

2

MD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

in the past 12 months? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

1 Yes

24a. Was an autopsy performe 1 ☐ Yes 24 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year) 5 Pending

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 X Natural 2 Accident 3 ☐ Suicide 4 Homicide

investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) September 4, 2008

SICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 350 VAN

State Registrar 31. Date filed (Month, Day, Year) 2008



			1 - For State Registrar	State Of Mi	ai yiai i		rtificate of	Death		Reg. No. 2	08 30018
	Physici	an	Decedent's Name (First, Middle,						2. Date of Dea Month	Day	3. Time of Death
M. Ja	/Medic	cal	4a. Facility Name (If not institution,	give street and number			Ab City Town o	r Location of Death	08		2008 2245 M
	Examin	ier	0	OWAL Mebici		Pender	4b. City, Town, o	ALIS BUM		4c. County o	ICOM ICO
	Funeral		5. Social Security Number		je (in yrs. i	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		Birthplace (State or Foreign Country)
	Director		218-16-8321 Usual Residence of Decedent	TIM ZINF	83	Yrs.			01-28-		Maryland
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-fst	ctor	MD Wicom	ico	Sa	lisbur	·V				1 Yes 2 □ No
:	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Country?
	s 23a	eral	4786 Dividing		C 1- 11-		21801			USA	
0	filed within 72 hours after death with the Maryland Hyglene. Hyglene, then "natural", or Items 23a or 28a-f show ant, the most be notified at ant, the most be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		5.   13.	if Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	- American Indian, , White, etc.
5-0036	ral", o	d by	3 ☐ Widowed 4 ☐ Divorced	ed 1 □Yes 2 ☑ If Yes, Give Year or Dates:			1 □ Yes 2 No	Specify:		Specify:	White
ָה ה	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occup	oation during most of work d)	king	16b. Kind of Bus	iness/Industry
7	d within glene. rr than	dwc	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Own		d) -		Restaura	ant
		Be C	17. Father's Name (First, Middle, L.	none		OWI	·CI	18. Mother's Nam	e (First, Middle,	Maiden Surname	
/land	uid be Venta rrked ric ev	P B	Clayton Bromley	7				Myrtle	Beauchar	np	
Mar)	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationshi Dean Murray/Son	p (Type. Print)		19b. Mailir 4786	ng Address (Street Dividin	and Number or Ru	ral Route Numbe alisbury	er, City or Town, S	State, Zip Code) 801
ore,	of He of He rothe		20a. Method of Disposition		20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place	ce)	Date	20c. Location - C	City or Town, State
Баітіто	ment ment tant: I		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			lem U.	M. Cemet	ery 09/0		Pocomoke	e, Maryland
ה מפו	Depar Mpor Iny in		21. Signature of Funefal Service Li	censee		22 H	Name and Addre	ess of Facility	e		
	202 40		23a. Part 1. Enter the disease, or c	Kay Ji	MOO2	95   1	1673 Some	erset Ave	., Princ	cess Anne	e, MD 21853
	huniaian		shock, or heart failure. List o	nly one cause on each li	ne.	i. Do not em	er the mode or dyn	ig, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	hysician /Medical	U	disease or condition resulting in death)	a. HYPOXI		ience of):					Bewinger
E	xaminer		O and a state of the state of t	P. Busais		10/100 01/.					INEEL
7	D +ig	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ience of):					
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POX	tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcome 1 ☐ Live birth			∃Ectopic pregnanc	·v			of delivery
. j	requires that the death ce been signed by the attendit should be detached for use	Physician/I	in the past 12 months? 1 □ Yes 2 █ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify) _		<u> </u>	Mon	th Day Year
Γ	ned by detac		Part II. Other significant condition	s contributing to death b	ut not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contril	bute to the cause of death?
Records,	quires en sign uld be	ed by	COPPER-VASCULAR &	DECIDENT					1 □ Y	res 2 No 3	3 ☐ Probably 4 ☐ Unknown
	as been s 2 should	Completed	Hyportonzion						24a. Was a		ere autopsy findings available
r	ate h	No.	1						autop perfor 1 □ Yes	rmed?de	ior to completion of cause of eath? □ Yes = 2 No
VILAI	ector,	Be (	25. Was case referred to medical examiner?					26. Place of Dea			
5	Aning ruysician: The law h. After this certificate has funeral director, page 2 a	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatier 28b. Time o	ot 3 DOA Oth	4 LI Nursing H		dence 6 Othe	
VISIOII OI	th. : Affe	Certification: To	1 Natural 5 Pending 2 Accident investiga	(Month, Da	iy, Year)	Injury	Wor	ryat k?  Yes 2. □No	28d. Describe n	now injury occurred	a
<u>אַ</u>	ector by the	ifica	3 Suicide 6 Could no	t bo	ury - At ho	me, farm, str	eet, factory, office		28f. Location (S	Street and Numbe	r or Rural Route Number,
2 5	al Dir	Cert	4 🗆 Hornicide	building, et	c. (Specify	'/ 			City or Tow	vn, State)	
2007	within 54 hours after death.  To the Euneral Director: After this certificate has been signed by the attendiction filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 ☐ Certifying (Check only one)  1 ☐ Certifying 2 ☐ Medical E.	Physician: To the best xaminer: On the basis o and manner sta	of examinat	wledge, deat ion and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
Ę	Vith Com	Ž	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed	(Month, Day, Year)
			Muhos H	for with			り の 3	भाड्या		9-5	2-2008
5	EB		30. Name and address of person w	ho completed cause of d	leath (Item	23a) (Type,	Print)	all we	218	- noon	Month, Day, Year)  2- 2008  Nond Horpital
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month ances 31, 2008 4:45A Aug. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

O I. Vrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☐ M 2 🔀 F 216-22-1742 84 1924 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 E. Main St. 21769 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Wever Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) power co. 12 secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francis H. Darner Ruth Rebecca Holter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Mende (Cousin) 3020 Marker Rd., Middletown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Mg Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Reformed cemetery 9/4/08 Middletown, MD 21. Sign ture of Furera S ... Lions 22. Name and Address of Faculity Donald B. Thompson Funeral Home caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leach line. Approximate Interval Between Onset and Death Part1. Enter the disease, or some shock, or heart failure. List only lications that Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months! Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 - Toursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending 1 Yes 2 No investigation 2 TAccident 6 Could not be determined 3 El Suicide

Examiner P.O. Box 68760 Division of Vital Records, To the newspace within 24 hours after death.

To the Funeral Director: Aft

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-fahov

othert

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any injury or other traumatic avent 90cg.

Physician /Medical Director

Funerai

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Examiner

Physician/Medical

Completed

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Certification:

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31. Date filed (Month, Day, Year)

29a. Certifier

State Registrar

After this c funeral dire

29b. Signature and litle of certifier

04

29c. License number D3518

1 Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and ad ress of per on who complete cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

West 9th street Frate

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** JULIA WILSON DOUGLAS SEPT. 2, 2008 02:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HERON POINT CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Funeral 1 M 2 XF Director 072-16-2994 85 5/7/1923 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "naturai", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐XYes 2 ☐ No Director MD KENT CHESTERTOWN 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1 CHESAPEAKE WING HERON POINT 21620 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after Hygiene. Hygiene. 1 Never Married 2 Mamed 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: WHITE Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ADVERTISING EXECUTIVE FASHION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I of Health and Menta ARTHUR WILSON GEORGIA (UNKNOWN MAIDEN NAME) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORRIS SCOTT/FRIEND PO BOX 354 CHESTERTOWN, MD 21620 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of important; If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 9/2/2008 STEVENSVILLE, MD . Signature uner Servige Licens e 22. Name end Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD, CHESTERTOWN, MD 21620 Kuy Os on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complicat shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Physician year Ulmer /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably has been ge 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page director, Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 7. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation atural 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Division or Vital Records, To the Hospital or Attend within 24 hours after death To the Funeral Director: / filled in by the

State Registrar

31. Date filed (Month, Day,

Medical

29c. License numbe

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

n who completed ca Name and address of pe se of death (Item 23a) (Type

2008

6 ☐ Could not be

Year)

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008<sup>Year</sup> **Physician** SEPT. 1010 **JERRY** RAY DOLDER 3, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 8. Date of Birth (Month, Day, Year) 6. Sex 1 X M 2 ☐ F If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Hours ILLINOIS 55 1952 Director 321-44-9642 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 □ No Director DE SUSSEX SELBYVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? tems 23a Funeral 48 WEST McCABE STREET 19975 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. In Important: If item 27 is marked other than "natural", or itel important: If item 27 is marked other than "natural", or itel any Injury or other traumatic event, Its Medical Examples once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 🔀 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 CONSTRUCTION WORKER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALMA JEAN KLINEHAN FRANK E. DOLDER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALMA JEAN RUTH, MOTHER P.O. BOX 781, SELBYVILLE, DE 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/4/08 CREMATORY OF DELMARVA DELMAR, DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 Part Enter the disea &, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh , or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical ence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy al or Attending Physician: The safter death, In Director: After this certificate 2 NO 2 🗆 No 1 ☐ Yes 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 → Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital c within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Mame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

08-06469 Glenn C Ellis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lenn C Ellis	State of Maryland / Department of He 1-For State Certificate of De	ealth and Mental Hy eath	giene Reg, No.	2008 3002
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death	3. Time of Death 2215 hrs
ledical Examine	GLENN C. ELLIS		Month Day Y August 23, 2008	y of Death .
	4a. Facility Natile (in Not institution, give offer and nemer)	ty, Town, or Location of Death inton		George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YY	YY) 9. Birthplace (State or Foreign Country)
Director	217-47-8849 1 M 2XF 12 Yrs. N	onths Days Hours Min.	July 21,19	
	Usual Residence of Decedent			10d. Inside City Limits
ow an	10a. State 10b. County 10c. City, Town or Location MD Montgomery Germant	own		1 X Yes 2 No
the Maryland t or 28a-f show any lifted at once. Director	10e. Street and Number	. Zip Code	10g. Citizen of	
th the Maryland 23a or 28a-f she notified at once	13525 Duhart Road	20874		S.A.
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Armed Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Yes, s	cedent of Hispanic Origin? (Sp. pecify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Ra W	ace - American Indian, Black, hite, etc.
er death	Never Married 2 Married 1 Yes 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify:	Specia	by Black
urs afte	or Dates:	sual Occupation (Give kind of w of working life. DO NOT use retir	OIII GOIIG	Business/Industry
3036 within 72 hours lene. er than "natur Medical Exam	Elementary/Secondary (0-12) College (1-4 or 5+)		Lar.	l B. Wood dle School
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan	7th Stu	18.Mother's Name	(First, Middle, Maiden Surna	
21215-0036 Mental Hygiene Merkel Hygiene re event, the Medica	ol Glen C. Ellis	Jari	ta A. Merc	er
212 hould b ad Men is mar tic eve		dress (Street and Number or F	Rural Route Number, City or	Hill, MD 0745
MD nd 2 sho alth and m 27 is	20a Method of Disposition 20b. Place of Disposition	(Name of cemetery,	Date 200. Locati	on - City or Town, State
Baltimore, MD 2 permit. Pages 1 and 2 shou Oppartment of Health and Nimportant: If item 27 is injury or other traumatic	1 X Burial 2 Cremation 3 Removal from State Cate of H			lver Spring,MD
it Pa	4 Donation 5 Other Specific 21. A nature of Funeral Service Licens 4: 22. Nam	e and Address of Facility	OWDER FURE	RAL HOME, P.A.
Balti permit. Departu Import	Mario X Graces 1 246			ville, MD 20850
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	node of dying, such as cardiac o	or respiratory arrest, shock, o	Between Onset and Death
'Medical'	Immediate Cause (Final disease or condition resulting in death)  a. Shotgun Wound of Head  Due to (or as a consequence of):			
	Sequentially list conditions, b	1		
	if any, leading to immediate  cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
ie be ex sysiciar burial			23d. Da	ate of delivery
yrds, P.O. Box 68760, w requires that the death certificate be sheen signed by the attending physic should be detached for use as the burnshould b	23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic pregn	ancy Mor	nth Day Year
OX (eath ce attence attence for use	y past 12 monator 4 Pregnant at time of death 5 Othe 1 Yes 2 ✓ No 9 Unknown g Unknown	- (Specify)		
Records, P.O. Box The law requires that the death create has been signed by the atter page 2 should be detached for u		lerlying cause given in Part I.		contribute to the cause of death?  3 Probably 4 Unknown
ires that signed is be de				24b. Were autopsy findings available
cords law requested has been been been been been been been bee			autopsyperformed?	prior to completion of cause of death?
Recc The lav		26.Place of Death (Chec	1 Yes 2 No	1 Yes 2 No
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outnatient	IOther:	ing Home 5 Residence	6 Other:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	1 Ves 2 No 28a Date of Injury 28b. Time of Injury		28d. Describe how injury of Subject shot	occurred
Sion of Attending Ph. death. ctor: After toy the funeral	Periodical Control of the Control of	1 Yes 2 V No	1	Deat Death Number City
IVISIOF or Attency after death Director:	28e. Place of Injury - At home, farm, street 3 Suicide 6 Could not be	factory, office building, etc.	or Town, State) 10403 Farrar Avenue, (	Number or Rural Route Number, City Cheltenham, MD
bou hou		d at the time, date and place, a	and due to the cause(s) and m	nanner as stated.
the He hin 24 the Fu	29b. Signature and title of certifier  Calcifornia 2 Certifying Physician: To the best of my knowledge, death occurred one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred	d at the time, date and place,	and due to the cause(s)
	29b. Signature and title of certifier	29c. License number	29d. Dat	e signed (Month, Day, Year)
2	anel	O.C.M.E.	Augus	st 24, 2008
	30. Name and address of person who completed cause of death (Item 23a)	reet, Baltimore, MD 212	01	
	Attached to the Control of the Contr			
St Regist	te 31. Date filed (Monto ParyYear) 4 2008 32. Redistrar's Signature	and s		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Carroll Fern Fox September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hagerstown

If Under 1 Year | If Under 24 Hrs.

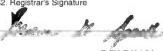
Months | Days | Hours | Min. Golden Living Center Washington County Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 578-62-9536 1 □ M 2 🕅 F 100 Director March 4,1908 Missouri Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Washington County Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21740 490 Thames St. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permin. rages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner in once. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No 3altimore, Maryland 21215-0036 Specify Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Norman Cornish Ina Elena Wheeler Cornish ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ina Masters-daughter 490 Thames St. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 9-9-2008 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease of combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as ed by the attending I IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 Other (specify) 9 🗌 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2:10 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attenc within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 115 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

3H-10

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of treath (Item 23a) (Type, Print) 32. Registrar's Signature

Manjen



Registrar

	1-	For State Registrar		State	of Ma	rylan	d / Depa <i>Cei</i>	artmen <i>rtificat</i>	t of H e of L	ealth : Death	and M	lental Hy	giene Reg. No	-	08	300	)24
hysician	1. 0	Decedent's Name Thomas		Last) .liam	Fre	eema	ın					2. Date of De Month 08-28	Da	908	Year	3. Time of 5:00	
/Medical xaminer		Facility Name (#				ome				Location MSPC					of Death	on	
neral ector	5. S	Social Security No. 18 – 20 – 9	835	5. Sex 1 <b>∑</b> M 2 □	7. Age	(In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 5 – 19 –	th 17, Year) 192	9	9. Birthp Cour PA	place (State ontry)	or Foreig
fled at	10a	ual Residence of a. State MD	10b. County	.ngton			,Town or Lo								1	0d. Inside C	
be notified by notified Director	106	e. Street and Nun		1.1				10f. Zip					-	izen of V	What Cour	ntry?	
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atic event, To Be C	17.	Father's Name (			an					Anna	a Ly						
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ant: # Rer ury or oth	208	a. Method of Disp 1 ☐ Burial 2 ☐ 4 ☐ Donation	Cremation :		om State	a	lace of Dispo emetery, crei ps Cr	emat	ther place ory		9-8-	-2008	Wi	nche	este	own, State	
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sician edical miner	lm dis re:	mediate Cause ( sease or condition sulting in death)	rtfailure. List o Final n	a	ETAS	e. TAT	12 8	RECT				om A	rrest,			Approxima Interval Be Onset and	tween
physician and its the burial-transit	res	quentially list cor any, leading to im use. Enter Unde luse (Disease or at initiated events sulting in death) L		C	o to (or as a												
d by the attending philetached for use as the physician/Medi	-	FEMALE: b. Was decedent in the past 12 1  Yes 2  9  Unknown	months?	1⊡Li 4⊟Pi	, outcome over birth tregnant at nknown	2 Fetal	Ideath 3[	Ectopic p							ite of deliv	_	Year
p p p	Pai	t II. Other signif	icant condition	s contributing	to death bu	it not resi	ulting in the u	nderlying o	ause give	en in Part	ł.			use cont	tribute to t	he cause of	death? Unknov
cate has been si page 2 should to Completed	-											24a. Was auto perfe 1 🗌 Yes			prior to co death?	opsy findings empletion of a	
director,	25	. Was case reference examiner?		Hospital:	I □ Inpatie	nt 2 🗆	ER/Outpatie	nt 3 🗆 D0	Othe			h <i>Check</i> only		6 🗆 Oth	ner (Speci	fy)	
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Compi	27.	Manner of Death  Natural  Accident	5 Pending investiga	ition (/	ate of Injur Month, Day	y Year)	28b. Time o Injury	f M	28c. Injun Work			28d. Describe		<del></del>			
To the Funeral Director: After completely filled in by the funeral Medical Certification:		3 ☐ Suicide 4 ☐ Homicide	6 □ Could no determin	ed 289. P	lace of Inju uilding, etc		ome, farm, st	reet, factor	y, office			28f. Location City or To			ber or Run	al Route Nur	nber,
pletely fil edical	29	a. Certifier (Check only one)	1⊠ Certifying 2☐ Medical E		the best on the basis of manner sta	examina	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my op	ne, date a pinion, de	nd place, ath occur	and due to the red at the time	date an	s) and made,	anner as s and due t	stated. to the cause(	s)
de comp		b. Signature and	title of certifier	10 ruh						number	0		^			Day, Year)	3
2+1	-	Name and addr	ess of person w	ho completed		eath (Item		-	5T			AMSPO	727,	MD	21	2008 795	J
State Registrar	_	. Date filed (Mon		2008	2. Redistra			Locals	,	<del></del>			•				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $p^{\,\text{M}}$ Vernon 26, Walter 2008 Gavigan Jr. August 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring
Under 1 Year | If Under 24 Hrs Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□ F Months Days Hours Min. 220-28-6914 Director 74 19, 1934 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Midical Evolution or use by notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7892 Poplar Grove Road 21144 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No. Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Andrews Air Force Base 12 Firefighter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental item 27 is marked o ၉ Walter Vernon Gavigan Ruth Elizabeth Whitehead 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Gavigan / Son 7892 Poplar Gro<u>ve Road; Severn, MD 21144</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 9/04/2008 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e O use (Final disease or condition resulting in death) Physician a. Sersis /Medical Due to (or as a consequence of): Examiner Pneumonia <u>Days</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 

Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Urinary Tract Infection 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No nours after death.

neral Director: After this certificat

y filled in by the funeral director, ps 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🕱 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 2 No 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 I Homicide within 24 hours a

To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a d title of certife D32332 August 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue #2-20, Silver Spring, MD 20902 Gupta, M.D. Suresh K.

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

of Vital Records.

Division

2008

08-06901 Kathleen Gray

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		tificate o		and wiente	R	Reg. No.	200	18 3002F
Physicia Medical Examin		Kathleen		G	ray		2. Date of Dea Month Septembe		Year 2008	3. Time of Death 0935 hrs
)		4a. Facility Name (if not institution, gi St. Mary's Hospital	ve street and number)			n, or Location of I	Death	40	lc. County of Death St. Mary's	
Funeral Director	- 1		Sex 7. Age (in yrs. las	ast birthday) Yrs	If Under 1 Y Months D	Year If Under 2 Days Hours	24Hrs. 8, Date of Bi		9. Bir Foreig 975 Co	irthplace (State or ign Washingtor ountr)) DC
land f show any. once,		10a. State 10b. County	Marys 10c. City, To	Town or Locat		gton Pa	ark			10d. Inside City Limits  1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral Director	10e. Street and Number 46841 South Sh				20653			tizen of What Cour	
		11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No ed If Yes, Give Year	If Y		ıban, Mexican, P	n? ( Specify Yes or No Puerto Rican, etc.)	)-	14. Race - Ameri White, etc.	ack
2 hour	Completed by	45 D 1- 11 E1 (0 15	or Dates:	16a. Deceder during m	ent's Usual Occup most of working I	upation (Give kin life. DO NOT us	nd of work done se retired)	16b. l	Kind of Business/I	
215-0036 be filed within 72 ntal Hygiene. rked other than " ent, the Medical I					hier		Name (First, Middle, I	Maiden	· .	
MD 21215-0036 d.2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than an market ovent, the Medica	2	Daniel 19a. Informant's Name/Relationship (* John Gray/ Bro			ng Address (Str		V per or Rural Route Num .Capital		City or Town, State	Savoy e, Zip Cod <u>9</u> )0743 Marvland
Baltimore, MD 212 permit Pages land 2 should be Department of Health and Ment Important: If item 27 is mark injury or other transmatric ever	- 1	20a. Method of Disposition  1 Burial 2 X Cremation 3  4 Donation 5 Other Specify	20b. Pla Removal from State cre	lace of Dispos rematory or oth	sition (Name of	f cemetery,	Date 9/17/08	20c. I	Location - City or	
Balt permit Depart Impor injury		21. Signature of Funeral Service Licer	19	22. N	Name and Addre	ress of Facility 7	Adams Fur Rd.Aquas	ner	cal Home	e PA and 20608
Physician /Medical 			echine a.Cardiomegaly and	Do not enter that ad left	the mode of dyin	ing, such as card	diac or respiratory arm	rest, sho	ock, or heart	Approximate Interval Between Onset and Death
,	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
3 2 8 _	_	events resulting in death) Last  d.  X UNPENDED	Due to (or as a consequence of):  AMENDED 23a, PII,		or ME G	R84 107	2/08 TT			
Box 68760, ne death certificate be e the attending physician led for use as the burial physician and for use as the burial control of the state of the burial control of the state of the burial of the state of the	- 1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown	23c. If yes, outcome of pregnar  1 Live birth  4 Pregnant at time of death	ancy 2 Fet	etal death 3 ther (Specify)	3Ectopic pr			3d. Date of delivery Month D	y Day Year
P.O. Bc es that the dea igned by the a pe detached fo		Part II. Other significant conditions  Morbid obesit	contributing to death but not resu	ulting in the u	underlying cause	e given in Part I				the cause of death?
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the director of the funeral Certification. To Be Commission by Directors.	Completed by	1101011	y				24a. Was a autop:	an psy prmed?	24b. Were aut prior to co death?	utopsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page	a   a	25. Was case referred to medical examiner?	Hospital:			ace of Death (Ch	1 Yes :	2 No		
J of Vir Jing Physic After this funeral dir	۵,	1 ✓ Yes 2 No 27. Manner of Death	i inpatient 2 V Er	R/Outpatient 28b. Time of In		Other No	Nursing Home 5 28d. Describe h	Resider		:
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To the How within 24 h To the Fur completely		one) 2 Medical Examiner  29b. Signature and title of certifier	er:On the basis of examination and/o	or investigation	tion, in my opinic	ion, death occurr	rred at the time, date a	and place	Date signed (Mon	ne cause(s)
		Thoday Mr. 30. Name and address of person who de	Manual of death (Nem 2)	4D.		C.M.E.	OCME		otember 10, 20	
652		Theodore M. King, Jr., MD	D. Assistant Medical Exa	aminer *		street, Baltin	more, MD 21201	ı		
State Registra	e - ar_	31. Date filed (Month SEP 1 5	2008 32. Resistrar's Signature	1 April	ali					

			For State Registrar	State of M	arylan		artment <i>rtificate</i>			and M		giene Reg. No		30027	1
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- 26	Examir		4a. Facility Name (If not institution,				4b. City, To	own, or	r Location o	of Death		4c.	County of Death		
			BayWoods Healt				Annap		S If Under:	Od Uro	0. 0		nne Arun		_
	Funeral Director		577-40-3266	. Sex 7. Ag	77	last birthday) Yrs.		Days	Hours	Min.	8. Date of Bird (Month, Da 08/18/1	year) 1931	Wash	place (State or Foreign ntry) ington, D.C.	
	Maryland	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince	George's	10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits 1 X Yes 2 □ No	
	or 28	Dire	10e. Street and Number				10f. Zip 0						izen of What Cou	•	-
	ath wi	rall	3015 Stonybrook					)715					ted Stat		_
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land 2	s 1 and 2 should be filed w f Health and Mental Hygie Item 27 is marked other ti other traumatic event, In	To Be Co	17. Father's Name (First, Middle, La John Lopez	est)		IllSuf	ance A	igen	18. Mothe		(First, Middle,		Surance Surname)		_
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Baltimore,	permit. Pages 1 a Department of Her Important: If item any injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	cify)		Place of Dispo cemetery, crei 1as Cr	emator	ĵу	;0	8/31		Edge	· · · · · · · · · · · · · · · · · · ·	Maryland	
Bal	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service un	chsee									as Funer gewater,	al Home MD 21037	
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<b>)</b>	36gr		30. Name and a Press of person w	operated cause of a Valvo).	death (Item	n 23a) (Type,	Print) T	hi	العاد	lle	Rd	BO	wil n	1/2071	5

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0757 M ARTHUR VINCENT GRIFFIES, SR. 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINGULA OBBIONAL MEDICAL CONTRE wicom wo 18B If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 424-46-4202 68 SEPT.19,1939 Director ALABAMA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, "we Madical Evaninar must be notified at DELAWARE SUSSEX SEAFORD 1 □Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5155 WOODLAND FERRY ROAD 19973 AMERICA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 💥 No Specify: WHITE ⋧ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 UNION Elementary/Secondary (0-12) College (1-4or 5+) INTERNATIONAL REP 12 12 should be filed whand Mental Hygieu 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLEM CHESTER GRIFFIES KATHRYN ROCKHILL 195. 11-51119 Addition Of the Anning of the Run Anning of the City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important; If item 27 is r any injury or other traur once. MARILYN B. GRIFFIES WIFE SEAFORD, DELAWARE 19973 Baltimore. 20b. Place of Disposition (Name of WOODLAND TO CHURCH 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/6/08 WOODLAND, DELAWARE 4 Donation 5 ther (Specify) CEMETERY 2WATSON TES FUNERAL HOME, INC. FRONT & KING STREETS SEAFORD, DELAWARE Approxim Interval Between Onset and Death complications tha caused the only one cause of each line. 23a. Part 1 F er th iseas sh , or heart failure. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immenste Cause (Final disease of Addition resulting in death) Stroke **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Examine Due to (or as a consequence of) certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of). Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ed by the a 1 □ Yes 2 □ No. Ö 9 Unknown ۵. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performed certificate h 2 🗆 No of Vital 2-EINo 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation death, 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 ☐ Suicide 6 □Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Hospital 29a. Certifier **♦** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10053394 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury md 2180 100 €. FREY mD ANTHONY 5.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

08-06561 Ralph Dale Hodge,		pe or Print in B	l / Departme	nt of He	alth and			egible.	000 2002
Physician/	Registrar 1. Decedent's Name (First, Mid	· · · · ·	Certifica	te of Dea	auri 	MET	2. Date of De	Day Ves	3. Time of Death
Medical Examine	Ralph Dale Ho  4a. Facility Name (if not institu	J .	r)	4b. Cit	y, Town, or L	ocation of Death	August 2	7, 2008 4c. County of	1738 nrs
	Prince Georges Hos	·			everly			Prince G	
Funeral Director	5. Social Security Number 212–31–9866	6. Sex 7. A	ige (In yrs. last birth 17		Inder 1 Year Inths Days	If Under 24Hrs Hours Mir		•	9. Birthplace (State or Foreign Country Mary land
any	Usual Residence of Decedent 10a. State 10b. Count		10c. City, Town o	or Location					10d. Inside City Limits
<b>*</b>	$\mathbb{C}$		Washir	ngtan				9	1 X Yes 2 No
the Maryland a or 28a-f sh	10e. Street and Number 4631 Blaine Street	t, N.E.		10f.	Zip Code <b>20019</b>			10g. Citizen of Wh	nat Country?
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status	12. Was Deceder  Armed Forces	s?		edent of Hisp	anic Origin? ( S Mexican, Puerto			- American Indian, Black, e, etc.
s after d	3 Widowed 4 [	Divorced If Yes, Give Year or Dates:	2 <b>X</b> No		2X No	AND DESCRIPTION OF		Specify:	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene and: If item 27 is marked other than "natural", or other transmatic event, the Medical Examiner.  To Be Completed by 1	15. Decedent's Education (S Elementary/Secondary (0-1:			uring most of	working life. I	on (Give kind of DO NOT use ret		16b. Kind of Bu	•
5-003 ed within ygiene. other the he.Medi	17. Father's Name (First, Midd	le, Last)		Stude		8.Mother's Name	e (First, Middle	N/A , Maiden Surname	
:1215 lid be filed Antal H narked event, il	Ralph Dale Hodg		10h	Mailing Adds	OC (Steed	Tina C		umbes City as Tour	P. Chata 7: Code)
MD 21 42 should th and Me 127 is ma umatic ev	Tina Lindsay - Mo		46	31 Blair	ne Stree	t, N.E.;			n, State, Zip Code) 20019
nore, ages l and nt of Heal t: If iten other tra	20a. Method of Disposition  1 X Burial 2 Cremati		State cremato	Disposition (In Disposition (In Dispos	ace)		Date 03/2008	20c. Location -	City or Town, State
Baltin permit. Pa Departmer Importan Injury or	4 Donation 5 Other 21 Signature of Funeral Servi		7/	22. Name a	and Address	of Facility <b>Free</b>	eman Funa	ral Servic	es
Physician	23a Pirt I. Enter the disease,		ed the death. Do not					Maryland rrest, shock, or he	art Approximate Interval
/Medical Examiner	Immediate Cause (Final disea or condition resulting in death	se a. Multiple Gunsh							Between Onset and Death
	Sequentially list conditions,	b							
red nisit Examiner	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	C							
executed ian and all - transit	UNPENDED	dAMENDED							
760, ficate be g physici the burit	IF FEMALE: 23b. Was decedent pregnant in	the	ome of pregnancy			75-4		23d. Date of	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans edical Certification: To Be Completed by Physician/Medical E.	past 12 months?	I Live birti	at time of death 5	Fetal dea		Ectopic pregn	ancy	Month	Day Year
P.O. I so that the gned by the e detache	ľ	ditions contributing to dea	ath but not resulting	in the underly	ying cause giv	ven in Part I.			ibute to the cause of death?  Probably 4 Unknown
Records, I The law requires ficate has been sig , page 2 should be Completed							24a. Wa		Were autopsy findings available orlor to completion of cause of
Reco							1 ✔ Yes		death?  ✓ Yes 2 No
Vital ystcian: this certi	25. Was case referred to medi examiner?	Hoonital:	tient 2 🗸 ER/Ou	tpatient 3		of Death (Check Other 4 Nursi	ng Home 5	Residence 6	Other:
on of Vit neting Physic th. After this see funeral dire	27. Manner of Death	28a. Date of In (Month, Day Aug 27, 200	njury 28b. T 18 <sup>ear)</sup> 1709	ime of Injury hrs	28c. Injury	at Work?	28d. Describ Subject st	e how injury occurr ot	red
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted deated.	2 Accident Inv	vestigation 28e. Place of	Injury - At home, far onvenience Sto		tory, office bu	ilding, etc.	or Town		er or Rural Route Number, City
To the Hospita within 24 hour To the Full to the Completely fillers	29a. Certifier (Check only)	Physician: To the best of examiner:On the basis of ex	my knowledge, deat	th occurred at			d due to the ca	use(s) and manner	r as stated.
To the within To the company of the	29b. Signature and title of certi	and manner stated			29c. License		at the time, da		ed (Month, Day, Year)
	Down	OIM , MO			O.C.N	1.E.		August 28,	2008
er a	30. Name and address of personna M. Vincenti, I			111 Pen	n Street,	Baltimore, N	MD 21201		
State	31. Date filed (Month, Day, Yea		rar's Signature	9					

DHMH 17 Rev 1/2001 OCME 2006 OPIG

OCME

/ern	etta Haizlit		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar 9-15-08Amend#1 PerMFOPGCETtificate of Death 1 Department's Name (First Middle Last) 1 Department's Name (First Middle Last)	Reg. No. 2008 3003
Mod	Physicia dical Exami	ELD/		
wec	iicai Exami	ner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death
	Ц.		Fort Washington Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date	Prince George's  of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
	Funeral Director		007-56-2678 1 M 2XF 46 Yrs. Months Days Hours Min. 11	/09/1961 Country) WV
	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	e Maryland or 28a-f show fied at once.	tor	MD Prince George's Fort Washington	1 X Yes 2 No
0	death with the Maryland or items 23a or 28a-f sho	I Director		10g. Citizen of What Country? USA
•	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		
	iours af natural xamin	od be	lor Dates:	16b. Kind of Business/Industry Veterans
	036 within 72 h ene. er than "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Administrative Assista	nt Administration
	215-C be filed v ntal Hygi rked oth ent, the	Be Co	Edward Smith, Jr.   Virdel One	al
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important; If item 27 is marked other than nijury or other traumatic event, the Medica	2		wite Number, City or Town, State, Zip Code) Wash., MD 20744
	ore, I ges I and t of Healt t If item		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Maryland Veterans 9/17/2	20c. Location - City or Town, State
	altim mit. Pag partment portant: ury or o		21. Signatur of Funeral Service of ensemble 22. Name and Address of Facility Str1C	cland Funeral Services
		8 0	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral	Camp Springs, MD 20748 tory arrest, shock, or heart Approximate Interval
	Physician /Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic cardiovascular disease  Due to (or as a consequence of):	Between Onset and Death
		-	Sequentially list conditions,  if any, leading to immediate  Due to (or as a consequence of):	
	d sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):	
	' <b>60,</b> sate be executed physician and ne burial - transit	dical	X UNPENDED AMENDED 23a,PII,27,perME, G883 9/30/08 TT	
	687 certific nding	š	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery  Month Day Year
	ires that the d signed by the	by Ph	>	e. Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 V Unknown
	ds, F equires een sign ould be			a. Was an 24b. Were autopsy findings available
	Vital Records, P.O. Box hysician: The law requires that the death this certificate has been signed by the atte I director, page 2 should be detached for u	Completed		autopsy prior to completion of cause of death?  Yes 2 No 1 Yes 2 No
	/ital /sician: /sician: /sicerti director	o Be	examiner?	
	n of \ding Phy. h.: After the funeral of		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. De	escribe how injury occurred
	Division of all or Atter s after deat all Director ed in by the	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or	cation (Street and Number or Rural Route Number, City Fown, State)
	Division of Vital Records To the Hospital or Attending Physician: The law requi within 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	ledical Ce	Homicide  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to to the control of the c	he cause(s) and manner as stated. e, date and place, and due to the cause(s)
	To with To Corr	Med	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
			O.C.M.E.	September 7, 2008
12			30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01
	S Regis	tate trar		OGME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 SEPT. **Physician** 01:28 AM 4. HENNESSY ANN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KENT ROCK HALL 21997 KELLY PARK RD. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/28/1929 **Funeral** Months Days Hours Min. 1 □ M 2 □ XF MD 218-28-3086 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Experiment must be notified at 1 □Yes 2 No ROCK HALL Director MD KENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21997 KELLY PARK RD. 21661 USA Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: WHTTE Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other this any injury or other traumatic event, thu 12 **PSYCHOLOGY PSYCHOLOGIST** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ LEROY J. HENNESSY NELLIE L. ZIEGLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) POST OAK RD. ROANOKE, VA 24019 CHRISTINA ROMANIK/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION: 9/5/2008 STEVENSVILLE, MD 22. Name and Address of Facility 21. Signature of Euneral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Dul 23a. Part 1. Enter the disease, or contrications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician war RECTAL CANCER METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy ō Day Year 5 Other (specify) 1 ☐ Yes 2 No o signed by the <u>a</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 ☐ Other (Specify) Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 2 Accident 5 Pending ours after death.
neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description:
The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Special Chesterlain, MD 21620 120 32. Regist 31. Date filed (Month, Day, State **5 2008** ▶ Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** EUGENE EDWARD HOUGHTON AUGUST 31, 2008 07:40A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 27493 MORGNEC RD. CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F 10/31/1940 184-30-1516 67 NJDirector Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD KENT CHESTERTOWN 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27493 MORGNEC RD. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 l (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) THOROUGHBRED HORSE BREEDER 12 HORSE BREEDING 12 should be filed whand Mental Hygiel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be T. BERNARD HOUGHTON MARIE CARROLL injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 is m any injury or other traum ELIZABETH HOUGHTON/WIFE 27493 MORGNEC RD. CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 9/2/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Kuto Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 5 mattes disease or condition resulting in death) donothic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Exami and Due to (or as a consequence of) Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0 the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform 2[ Attending Physician; 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home ပို 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) y To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Low M.D 17036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ressmo. 516 Wishington enter toon ma 2162 32. Registres Signature 31. Date filed (Month, Day, Year) State 2008 Registrar SEP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Gregory Allen Harris /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO oastal Hospice at alisbury If Under 1 Year | If Under 24 8. Date of Birth (Month, Day, Nov 12, Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1962 218 88 9791 Washington DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Exa<u>miner must be notified at</u> 1 ☐ Yes 2 ☐ No MD Worchester Funeral Director Bishopville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11314 Marie Drive 21813 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after NYYes 2 ☐ If Yes, Give Year or Dates: <sup>2□No</sup>1982 1 Never Married 2 Married 1 ☐ Yes 2 ☐XXX Specify: White Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 1985 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry J Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver Services ulth and Mental Hygi 27 is marked other r traumatic event, tl 18. Mother's Name (First, Middle, Maiden Surname) Itimore, Maryfand 17. Father's Name (First, Middle, Last) Be Matthew Harris Connie Wyvill 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any Injury or other trau Matthew Harris (Father) 826 9th Ave, #FS, New York, New York 10019 20a. Method of Disposition
1 Description 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 9, Dat 2008 20c. Location - City or Town, State Maryland Veterans Cemetery Cheltenham, Maryland 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Juneral Service License 0 Alexandria Ferry Road, Clinton, MD 20735 23a. Part . In the di shock, or leart fa Approximate Interval Between Onset and Death omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Couse (Find disease or condition resulting in death) MRTASTATIC **Physician** LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence off the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the buria ast IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) ed by the a 9 Unknown s been signed by the should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 → es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 → No 24a. Was an has autopsy certificate To the Hospital or Attending Physician: After this certification funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 14 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after dear To the Funeral Director completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20058410

State Registrar

DHMH 17 Rev 1/2001

Bop # 1733 SACCIONAYUND 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

COASTAZ

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HOWES **Physician** Month 8 2345 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 8/2/1939 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months Min. Hours 219-38-2434 1 M 2 K F 69 (Country) Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar quat be notified at MD Anne Arundel Churchton Director 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5705 Blaine Rd. 20733 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 3EXNO Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: \$ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental 1 and 2 should be of Health and Menta Item 27 is marked r other traumatic ev Milton Howes Alice Ford ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5705 Blaine Rd. Churchton, MD 20733 19a. Informant's Name/Relationship (Type. Print) James R. Howes Spouse 5705 Blaine Rd. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Itel
any Injury or ott Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodfield Cemetery 9/5/2008 Galesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 21. Signature of Funeral Service Licenses Jahr 12 Ridgely Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Chom **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Dav Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Left Hip Fracture 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 □Yes 2 □No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Te Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 X Accident 5 Pending May 25, 2008 4:00  $p^{M}$ 1 ∐Yes 2 🙀 No investigation subject fell. Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5705 Blaine Road 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Home CHurchton, MD within 24 hours a

To the Funeral C To the Hospital 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 445 PE FENSE ALGHWAY ANNARUL MOLIYOF son wife completed cause of death (Item 23a) (Type, Print) Mo NTA La E 31. Date filed (Most 32 Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 30 11:15 PM Mary Jo Huff August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen BUNNic ANNE BAITIMORE WAShington Medical Arun Vel Center 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Director 291-18-6986 Oct. 24, 1924 Ohio Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show Director 1 ☐ Yes 2 No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Giddings Avenue 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: White 9 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any linury or other traumatic event, traingness. Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvatore Puglisi Guseppa Racuella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Huff/Son 10067 Long Branch Street Port Charlotte, FL 33981 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) September 4 Glen Haven Memorial Glen Burnie, MD 2008 21. Signature/of Funeral Service Licensee, 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** + Neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has be rector, page 2 sl 24a. Was an 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number D027415 August 30, 2008

State

DHMH 17 Rev 1/2001

Registrar

Washington Medical Center

BAltimore

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis

Year)

31. Date filed (Month, Day,

State

31. Date filed (Month, Day, Year)

SEP 0 3 2008

DHMH 17 Rev 1/2001

Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Z U U d 2. Date of Death 1. Decedent's Name (First, Middle, Last) Donth 08 Physician ONES 0340M ENJAMIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 21 1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Country) Oct 214-52-8750 57 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 28a-f show 1 ☐ Yes 2 No Maryland Anne Arundel Lothian Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 801 Ben Jones Lane 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: Specify: Black ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Reliable than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the one. the 12th O Construction Contractor's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ James Henry Jones Dorothy Marie Bias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mamie E. Brice(Sister) 1229 Marlboro Rd. Lothian, Md. 20711 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Mame of cemelery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Church Cemetery 9-6-08 Lothian, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Winname Remains of Acing ons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 darry S. 18en 1100483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EPATIC ACUTE Physician /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine he law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2**0** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform Segmes toph this certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 Tes 2 🗌 No within 24 hours after death

To the Funeral Director:
completely filled in by the 1 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Box 68760, Division or Vital Records, the Hospital or Attending Physician:

laryland 21215-0036

Baltimore,

State Registrar

29b. Signature and title of certifier

29c. License number

29d Date signed (Month, Day, Year)

leted cause of death (Item 23a) (Type, Rrint) MENM

31. Date filed (Month, Day, Year) SEP 0 3 2008 32. egistrar's Signature

1 - State Registrar Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Yea **Physician** Dem her 2,2008 lam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner NE ommunity If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State of Foreign Country) Age (In yrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) 12/29/1935 1 1 M 2 □ F 578-46-2605 72 Washington, DC Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Experience rust by motified at Director Maryland Prince George's Hvattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4920 71st Avenue 20784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 25 Married White egley, William 1 ☐ Yes 2 ☑ No Specify. 3 Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Stock Clerk Safeway, Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William L. Kegley, Sr. Grace Thorp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 st ment of Health ar Virginia A. Kegley - Wife 4920 71st Avenue, Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If its any Injury or o once. 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 9/5/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ardio pulmonery disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mvocardia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner The law requires that the death certificate be executed cute Exami burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Completed by Physician/Medical ANasarc IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. I ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Pan cytopenia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 his certificate for director, page 2 No of Vital 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To this 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

reorges

1 Yes 2 □ No

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

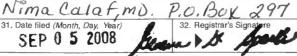
September 3,2008

Year

10 State

31. Date filed (Month, Day, Year) SEP 0 5 2008

29b. Signature and title of certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D0058976

Greenbelt, MD. 20770

			1 - State of Maryland / De State of Maryland / De Registrar	ertificate of Death	and Me		i. No. 2 () () 8	30039
	Physici	an	1. Decedent's Name (First, Middle, Last)		2	Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Jack Beachley KIMMEL  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location o	of Dooth	Sept.	7本 2008 4c. County of Death	1
	Examin	er	935 Guilford Avenue					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Hagerstown  ay) If Under 1 Year If Under 2	24 Hrs. 8	. Date of Birth (Month, Day,	Washingt 9. Birth	place (State or Foreign ntry)
	Director		217-28-6957 <sup>1</sup> ₹ <sup>M 2□ F</sup> 76 Yrs	Months Days Hours	Min.	July 30	1932 M	aryland
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	Location				10d. Inside City Limits
	Maryl -f sho	to	Maryland Washington	la coma horm				1 √ Yes 2 □ No
	r 28a	Director	Maryland Washington F  10e. Street and Number	10f. Zip Code		100	g. Citizen of What Cou	ntry?
	72 hours after death with the Maryland instural", or items 23a or 28a-f show dical Examinar must be notified at	al D	935 Guilford Avenue	21740	)		US	Α
	r deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	igin? (Speci	fy Yes or No-	14. Race - Ameri Black, White,	can Indian,
30	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 🔯 No Specify:			0	ite
3-003p	tural		15. Decedent's Education 16a, Decedent's Education	ecedent's Usual Occupation		1€	6b. Kind of Business/Ir	
ν Σ	hin 72 9. 3m "na	Completed	(Specify only highest grade completed) (G	ive kind of work done during most e. DO NOT use retired)	t of working	1//		,
V	ed wit	Con		Boat Operator			Military	
	be file	Be	17. Father's Name (First, Middle, Last)		·		aiden Surname)	
2	d Mer marke natic	2	Charles Kimmel			Lexandra		
<u> </u>	d 2 sl Ith an 17 is r traur			ailing Address (Street and Numbe				
<u>5</u>	s 1 an f Hea ltem 2	13		5 Guilford Aven sposition (Name of crematory or other place)	Dat		Wn <u>Mary La</u> Dc. Location - City or T	
ранишо	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Markeal Examiner must be notified at once.		I INDIBUTAL 2 LICIETTATION 3 LINETTOVALITOTT STATE	wn Mem.Garden	9/11/	08 н	agerstown,	Marvland
<u>=</u>	rmit. spartn porta y Inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility			uneral Hom	
_	90 F # 9		And L. Vishi	415 E. Wilson	Blvd.	Hagers	town, Mary	land 21740
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as	cardiac or r	respiratory arres	st,	Approximate Interval Between Onset and Death
***	Physician		Immediate Cause (Final disease or condition resulting in death)	Cancer				6 years
	/Medical Examiner		Due to (or as a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):					
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
5	e exe ian ar ırial-tı	Ex	resulting in death) Last  Due to (or as a consequence of):					
0000	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	<b>l</b> edical	d					
o XO	± 50, €	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy					
	seath atten	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli	very Day Year
Ċ	ding Physician: The law requires that the death cer. h. further this certificate has been signed by the attendir funeral director, page 2 should be detached for use	Physician//	9 ☐ Unknown 9 ☐ Unknown	(9,000,0)				
'n	gned oe det	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		23e. Did toba	acco use contribute to	the cause of death?
cords,	equire sen si ould b	ted				1 ☐ Yes	2 <b>₽ N</b> o 3 □ Pro	bably 4 ☐ Unknown
ຼັ	hasb	Completed				24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<u> </u>	n: The icate i, pagi	Co				performe 1 □ Yes 2		2 🗆 No
N I G	siclar certif	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ 1√10  Hospital: 1 ☐ Inpatient 2 ☐ EB/Output	Other:		Check only one)		
5	y Phy er this eral di	J: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at			ce 6 Other (Spec	ify)
	ath. r: Afte	atio	1 ☑Natural 5 ☐ Pending (Month, Day, Year) Inju 2 ☐ Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ !			, ,	
<u>≥</u>	r Atte er der recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28	f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
5	ital o urs aft ral Di							
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 ✓ Certifying Physician: To the best of my knowledge, d (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/cand manner stated.	eath occurred at the time, date an or investigation, in my opinion, dea	nd place, an ath occurred	d due to the car at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within some	Me	29b. Signature and title of certifier	29c. License number			d. Date signed (Month	
-	13		Michael Muloman M	0 0416	567		9.8.	08
1	3+1		30. Name and address of person who completed cause of death (item 23a) (Ty	0 0 4 16  De, Print)  Mediae/	<i>(</i> :		4 1	44.0
	Sta	te	31. Date filed (Months), Year 2009 32, egistrar's Signature	Iveniae !	cany	nus	Varento	en mu.
	Registr		SET US LUOS	Souls .				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 7, 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:00 P.M September 2008 Selma Knecht 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Homewood at Williamsport Williamsport If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7,1917 New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, November 1 □ M 2 🗙 F 90 154-09-2356 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Williamsport Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16505 Virginia Avenue 21795 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Department Stores Buyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aron Messer Rebecca Swyke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10826 Oak Valley Drive, Hagerstown, Md. 21740 Elizabeth Armel Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State B'Nai Abraham Cemetery 09-11-08 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 21. Signature of Funeral Service Licenses R. noch Brade 40 East Antietam Street, Hagerstown, Md. 21740 Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause/cr., ach line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate for the region of the cause (Disease or injury that initiated events resulting in death) Last as a consequence of) otoce No Due to or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? ificant conditions contributing to death bat 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

Department of Health and Mential Hygiene, Important: If item 27 Is marked other than any Injury or other traumatic event, The Ma once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner and burial-trar attending physician for use as the buria Physician/Medical signed by the a Ś Be Completed s certificate has t irector, page 2 s director, Medical Certification: To this n 24 hours after death.

ne Funeral Director: Af
pletely filled in by the fur

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown 3 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mapher of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

completely within 2 To the ٥

the

State Registrar

30. Name and address of p

29a. Certifier

29b. Signature

(Check only one)

gistrar's Signatu Del car

and manner stated.

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma		partment of H Pertificate of L			Jiene Jeg. No. 🥎 🗎 (	00 2001 1
			Decedent's Name (First, Middle,	Last)				2. Date of Dea Month		3. Tirhe et Death
	Physicia /Medic			Robert Torrey R	Kro11			September		008 8:50 am
mie.	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of I	Death
			Holy Cro	ss Hospital		Į.	Silver Spri	-		Montgomery
	Funeral Director		5. Social Security Number <b>415-14-9358</b>	6. Sex 7. Age 1 ▲ M 2 ☐ F	e (In yrs. last birthda <b>85</b> Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day September	Year) 9.	. Birthplace (State or Foreign Country) Maryland
	put		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	f sho	ō	59		, roon only, room or		er Spring			1 □Yes 2 No
	the N	Director	Maryland Mont  10e. Street and Number	gomery		10f. Zip Code	er spring		10g. Citizen of Wha	at Country?
	3a or		13210 Venetia	n Road			20904		Ţ	U.S.A.
	death	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S. 13	3. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race -	American Indian,
980	be filed within 72 hours after death with the Maryland that Hyglene.  ed other than "natural", or items 23a or 28a-f show event, the M-dical Exartinar must be notified at	ě	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ★Yes 2 N  If Yes, Give Year or Dates:	No.	1 ☐ Yes 2 🗷 No	Specify:	nican, etc.)	Specify:	White, etc. White
9.0	2 hou	ted	15. Decedent			cedent's Usual Occupa		dna	16b. Kind of Busin	
215	within 7 iene. than "n	Completed	(Specify only highes: Elementary/Secondary (0-12)	College (1-4or 5	life	ve kind of work done of DO NOT use retired	luring most or work  )	1		opkins University
2	filed wit Hygien other the	် မ		5+	<u> </u>	Technica				ysics Laboratory
nd	be filed vital Hygid double double double event, III	Be	17. Father's Name (First, Middle, L						Maiden Surname)	
<u>Ş</u>	should be land Mental s marked o umatic eve	은	Harry Harri					Annette		. 7. 0 ()
Mai	12 th 37		19a. Informant's Name/Relationsh		14	iling Address (Street				
o,	ges 1 and 2 it of Health If item 27 i or other tra		Mary Robinson -  20a. Method of Disposition	Daugnter		3 Magnolia P		Date	20c. Location - Cit	
Baltimore, Maryland 21215-0036	Paritimer tant:		1 ☐ Burial 2 🗷 Cremation 4 ☐ Donation 5 ☐ Other (Sp			position (Name of rematory or other plac oln Crematory	1	05/2008	Brentwo	ood, Maryland
Bal	permit Depart Import any In		21. Signature of Funeral Service L	icensee Ober		22. Name and Addres Hines-Rinald 11800 New Ha	i Funeral I			Maryland 20904
68760,	Physician and bulkician and bulkician and bulkician and bulkician and step physician and bulkician a	al Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Multi Due to (or as b. Atria Due to (or as c. Throm Due to (or as	ple Myeloma a consequence of): 1 Fibrillati a consequence of): bocytopenia a consequence of): Failure	on				Interval Between Onset and Death
O. Box	death cert e attendin d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome	of pregnancy 2  Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		23d. Date of Month	·
ds, P.	requires that the de een signed by the a rould be detached is	þ	Part II. Other significant condition		ut not resulting in the	underlying cause give	en in Part I.			ute to the cause of death?
of Vital Records,	The law ate has b page 2 sh	Completed						24a. Was a autop perfor 1 🗆 Yes	sy prio rmed? dea	ere autopsy findings available or to completion of cause of ath? ⊒Yes 2 □ No
<b>Zit</b>		Be	25. Was case referred to medical examiner?	Hospital:	00000	iont 3 DOA Oth	26. Place of Dea			(0. (1)
n of	ding Phys h. After this funeral di	ion: To	1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending	28a. Date of Inju		e of 28c. Injur	y at		dence 6 Other now injury occurred	
Division	or Attenter deat irector: I by the	Certification:	2 Accident investigation M 1 Yes 2 No						Street and Number vn, State)	or Rural Route Number,
	e Hospital of 24 hours af e Funeral Dietely filled in	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the best Examiner: On the basis o and manner sta	of examination and/or	eath occurred at the til r investigation, in my o	me, date and place pinion, death occu	e, and due to the trred at the time,	cause(s) and man date and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	T	29d. Date signed (	Month, Day, Year)
	2-41		Kshai	ma cro	ng		D60826		Septemb	er 2, 2008
	AT I		30. Name and address of person			e, Print)				
(	10)		Kshama Garg, N	1.D., 1500 Fore		i, Silver Spr	ing, Maryl	and 20910		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Fegistr	ar's Signature	Carles				

Ann Marie Kappler  Ann Marie Kappler  An Ann Marie Kappler  Ann Marie Caches Maried  Ann Marie Status  Ann Marie Caches Maried  Ann Maried Caches Maried  Ann	Death mery  D. Birthplace (State or Foreign Country)  Lew York  10d. Inside City Limits 1   Yes 2   No at Country?
Second   S	nery D. Birthplace (State or Foreign Country)  Iew York  10d. Inside City Limits 1 □ Yes 2 1 No at Country?  States  American Indian,
Ogg   Part   Ogg	Country)  Iew York  10d. Inside City Limits 1 □ Yes 2√ No at Country?  States  American Indian,
The property of the property o	1 □Yes 2★ No at Country?  States  American Indian,
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Elementary/Secondary (0-12)    College (1-4or 5+)   2   Secretary / Bookkeeper   Busine	
Elementary/Secondary (0-12)   College (1-4or 5+)   Secretary / Bookkeeper   Busine	White
Physician //Medical Examiner  Due to (or as a consequence of):	ness/Industry
Physician //Medical Examiner  Physician //Medical  Physic	-
Physician //Medical Examiner  Physician //Medical  Physic	
Physician /Medical Examiner  Physician /Medical  Immediate tarse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Control University of Hurby that initiated events resulting in death) Last  Due to (or as a consequence of):	
Shock or leart failure. List only one cause on each line.  Immediate Carse (Final disease or condition resulting in death)  Physician (Medical Examiner)  The property of the conditions of the	20852 Approximate
	Interval Between Onset and Death
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ves 2 12 No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)   Unknown   23d. Date 1   Month 1   Month 2   Month 3   Ectopic pregnancy 5   Other (specify)   Month 2   Month 3   Mont	of delivery h Day Year
	oute to the cause of death?  B□ Probably 4 🎖 Unknown
U s sq b sq c sq c sq c sq c sq c sq c sq	ere autopsy findings available for to completion of cause of ath? Yes 2 \( \square\) No
C 2 € 5 1 XI Natural 5 □ Pending (Month, Day, Year) Injury Work?	d
The second of the cause (s) and many second of the cause (s) and the cause	ner as stated.  nd due to the cause(s)  (Month, Day, Year)
J. 1000 63140 Aug. 3	30, 2008
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Jocelyne T. Kouatchou, M.D. 201 East University Parkway; Baltimore,  State  Positive  31. Date filed (Month, Day Year)  32. Registrar's Signature	

thin 24 hours a 2

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DHMH 17 Rev 1/2001

State

Registrar

Kala Davis - McDonald, MD - 821 N. Entaw Street #407, Baltimore, MD 21201.

MD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 0 4 2008 >

31. Date filed (Month, Day, Year)

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09/02

2008

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
AMEND TITEM#2, perPHYS., G883, 9/25/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 31 pay, 2008 **Physician** William Raymond Lankford 11:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Northampton Manor Nursing Center Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1X M 2 ☐ F Director 099-30-1945 June 29, 1927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1200-F Little Brook Drive 21702 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WW I I 1 ☐ Never Married 2X Married 1 ☐ Yes 21X No Specify: 3 <sup>Speciny:</sup> American Indian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Printing Lithographer 17. Father's Name (First, Middle, Last)unk. 18. Mother's Name (First, Middle, Maiden Surname) unk. Be Ethel ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200-F Little Brook Dr. Frederick, MD 21702 Beatrice Lawler / Wife 20b. Place of Disposition (Name of cametery, crematory or other place)
Restnaven
Memorial Gardens 20a. Method of Disposition Sept. Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  $2\overline{0}08$ Frederick, Maryland 21. Signature of Fuperal Service Ligans RESTHAVEN FUNEral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the insease, or comshock, or he in failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomyopalle **Physician** Severe months disease or condition resulting in death) /Medical Examiner mlh" Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 9-2-2008

DHMH 17 Rev 1/2001

State Registrar

Box 68760

P.0.

Records,

Division or Vital

801

Frederick.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zaidi MM

Saced 31. Date filed (Month, Day, Year) Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	T = For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H		, 0	ene g. No.2	108	30045
Physician	Decedent's Name (First, Middle, La     FANNY REBECCA I					2. Date of Death Month AUGUST	Day 29	Year <b>2008</b>	3. Time of Death  12:20PM M
/Medical Examiner	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death	HOGODZ	4c. Coun	ty of Death	
Funeral Director	220-22-9236	Sex 1 □ M 2 <b>X</b> F	97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCT 10,	Ye <i>ar)</i> <b>1910</b>	9. Birthp Coun MARY	
with the Maryland a or 28a-f show be notified at	Usual Residence of Decedent  10a. State 10b. County  MD TALBO	OT	10c. City, Town or Lo	cation				1	0d. Inside City Limits 1 Yes 2 No
th with the Ma 23a or 28a-f s st be notified al Director	10e. Street and Number 501 DUTCHMANS	LANE		10f. Zip Code <b>21</b>	1601	10	)g. Citizen o	f What Coun	try?
2 should be filed within 72 hours after death with the Maryland and Mental hygiene.  and Mental hygiene.  Tanked other than "natural", or items 23a or 28a-f show warmatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status  1 ▼Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1	lo I		Specify:		Spec	DLE	CK
be filed within 72 hor tral Hygiene. d other than "natural event, the Medical E Be Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	cade completed) College (1-4or 5	+) (Give	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of work ) PERVISOR	king	FOOD	SERVI	
2 should be filed with and Mental Hygiene. Is marked other than aumatic event, the M To Be Comp	17. Father's Name (First, Middle, Las  CHARLES BENJAMI	N LANE			FANNIE	e (First, Middle, N BLACKWEL	.L		
es 1 and 2 should b of Health and Menti filtem 27 is marked r other traumatic e	19a. Informant's Name/Relationship  ANDREA COGER/NI	, , ,	8532	MEADOWSV	WEET RD.,	BALTIMO	RE, M	D 2120	8
permit. Pages 1 Department of I- Important: If Ite any Injury or ot	20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 [  4 □ Donation 5 □ Other (Spec	ify)	COPPERSV	natory or other place	ERY 9/6			n - City or To	
Depar Depar Impo any Ir	21. Signature of Funeral Service Lice  23. Part1. Enter the disease, or cor	strowski C.	F.S.A FI	2. Name and Addres ELLOWS, HI DO_S. HARI	ELFENBEIN RISON ST.	, EASTON	i, MD	ERAL E 21601	Approximate
Crate be executed  Medical  Examiner  cdical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Tue to (or as a c.	a onseque ce of): a consequence of): a consequence of):	he cap	I for	i/ure	dist	154	Interval Between Onset and Death
t the death certification of the attending of the action o	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			- 1	Date of delive	ery Day Year
w requires that been signed the should be detailed.	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob 1 ☐ Ye		_	ne cause of death? ably 4
	25. Was case referred to medical	1					ned?	prior to cor death?	psy findings available inpletion of cause of
Physicia this cert al direct	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie			er: 4 Nursing Ho	th <i>(Check only one</i> ome 5 ☐ Reside	<i></i>	Other (Specif	y)
To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it Medical Certification: To Be C	27. Mann   f Death   1   Natural   5   Pending   investigation   3   Suicide   4   Homicide   6   Could not learning   Could not learni	oe Diago of inju	Year) Injury	M 1□	/ at (? Yes 2 □ No	28f. Location (St. City or Town	reet and Nu		il Route Number,
the Hospita in 24 hours the Funera pletely fille	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of iminer: On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my o	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and ate and plac	manner as s e, and due to	tated. the cause(s)
TLS Community	29b. Signature and title of certifier	THE 1	ND	29c. License	number 2 5 7 5 7 2		9d. Date sig	ged (Month,	Day, Year)
6	30. Name and address of person who ROBERT B. SANCE				ASTON, M	D 21601			
State Registrar	31. Date filed (Month, Day, Year) SEP. 0 3 2008	32. Registra	ar's Signature	6					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 800s Month **Physician** 2:40 AM Dorothy M. Lewis ΩÜ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSpice at the Lake 9 Wicomico SOUR If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 □ M 2 🛛 F 579-24-1048 82 4/23/1926 Director Washington DC Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f shov edi-al Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 203 Henry's Mill Dr. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify ģ Specify: white 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Cosmetology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ William Earl Crowl Olive Weaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Hall / daughter 455 Delso Ct., Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: It any Injury or Lakemont Mem. Grdns. 9/10/2008 | Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 1. Enter the dis. ase . . complications that caused the death. Do not enter the *m*ode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final RETROPERITONEAL CARCINON Physician MRTASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 profits?
1 ☐ Yes → ☐ No
9 ☐ Unkpown 23d. Date of delivery 3 Ectopic pregnancy Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> **1** No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1477 Yes 2 □ No Hospital: 1 Propatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 nours after death.

neral Director: After this
filled in by the funeral di 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

BAID

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

10100

State Registrar 29b. Signature and title of contifier

GHULLAM

31. Date filed (Month, Day, Year)

SEP 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL

Registrar's Signature

DHMH 17 Rev 1/2001

HOSPICE

29d. Date signed (Month, Day, Year)

Box 68760, P.0. Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 2008 1828 M JOHN W. LANCASTER, Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY Olney Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 □ F Months Days Director 218-20-1147 86 Feb. 10, 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its My dical Expr. incr. itst burnelling once. 1 ☐ Yes 2X No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20905 U.S.A. 2129 Edgeware Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ♣ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Self-employed Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eva V. Jackson John W. Lancaster, Sr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2129 Edgeware St, Silver Spring, MD 20905 Linda Lancaster (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem 9/6/08 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 1246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart milure. List only one cause on each line. Immediate Cause (Final LEROTI - COROWARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ∏Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending illed in by the f investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 19815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIKINCE Philip I Mix Begistrar's Signature Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month **Physician** W PETER MARTIN /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City. Town, or Location of Death **Examiner** rince HOSPITA They er ( 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 € M 2 🗆 F Months Days Hours Min. Director 578-72-5584 53 8/11/1955 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiens in remous auter urean with the Maryla Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exer, the first must be notified at once. **Funeral Director** 1 ☐ Yes 2 ☐ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3755 Jay Street N.E. 20019 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Completed by Specify Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrican Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Jessie Martin Cecelia Booth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3755 Jay Street N.E. Washington , DC 20019 Cecelia Martin / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₽ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Cemetery 9/8/2008 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 5538 Marlboro Pike Forestville, Maryland 20747 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death scan 23d Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? 2 🕅 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month **Physician** 09:50 AM 02 08 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Home Ó Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Days Months 1**½**M 2□F Hours Min. 3-46-6962 Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. artment of Health and marked other than "natural", or Items 23a or 28a-f show. 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edital Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Armed Forces? Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 2 No 1946 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Be Completed by Black 3 Widowed 4 ☐ Divorced 1947 infant: If Item 27 is marked other than "natu 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1h Pairmas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phila 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State P.O. BOX 33 Cemeta 4
Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) ice Licensee ennie FUNEVAL Part1. Enter the disc shock, of heart failu e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) Physician c/ /Medical Due to (or as a consequ ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2□ No 3 ☐ Probably 4 ☐ Unknown Completed Was an autopsy performed?
✓es 2 ✓ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 54422 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604- Market BARAL MD BA3+1

State Registrar 31. Date filed (Month, Day, Year)

0 5 2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No 2 U U 8 30050 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Ye ar 7:39 PM Charles Frederick MAY September 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) Dec. 25, 1 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Months Days Hours Min 1 X M 2 □ F 218-34-3627 69 Dec. 1938 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington 1 Tyes 2 No Fairplay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8835 Sharpsburg Pike 21733 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1957— 14 Race - American Indian. 11. Marital Status 1 Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify white 1961 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) co-owner/operator service station 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles William May Evelyn Mae Gladhill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. May - wife 8835 Sharpsburg Pike, Fairplay, Maryland 21733 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8, 2008 Sharpsburg, Maryland Mt. View Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Munelu uma Campos months disease or condition resulting in death) Due to (or as a consequencé of): 3 DA4) estruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lusto (or as a consequence of): Renel BONY failer Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 ⅓Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗆 No

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

Funeral

Director

28a-f show

the

with 1

should be filed within 72 hours after death

Pages 1 and 2

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experiment the rediffied at

Department of Health and Mental Hygiene, Important: If item 27 is marked other than any Injury or other traumatic event, ITEMS once.

Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burlar-transit this certificate has been sial director, page 2 should

Division of Vital Records, P.O. Box 68760,

Physician/Medical ģ Completed Be Certification: To

Medical

9 🗆 Unknown	a Chikhowii	
Part II. Other significant cond	lons contributing to death but not resulting in the underlying cause giv	⁄en in
	•	

autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

		7				(0,000.17)
27. Manner of Deat 1 Natural 2 Accident	h 5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)						e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29b. Signature and title	of certifier	
	M.A.	

25. Was case referred to medical

1 ☐ Yes 2 M No

almine

29d. Date signed (Month, Day, Year) 29c. License number 06,2008

	DW	lau					
Name and address of p	erson v	who complete	cause	of death	(Item 23a)	(Type,	Print)

BOONSBORD

State Registrar

To the within 2

DH7-1

31. Date filed (Month, Day, Year) 2008 08

Lopin



		٠.	_ For	partment of Health and N Certificate of Death	nental Hygler Reg. N	0000 00001	
	Physici	an	Decedent's Name (First, Middle, Last)     Thomas Earl Myers		2. Date of Death  Month	3. Time of Death 3:05 PM	
. 00	/Medic	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	September	1 2000 3:03 PW	
الخرر	Examin	ier	220 Rolling Road	Gaithersburg		Montgomery	
T	Funeral Director		5. Social Security Number 217-70-4141  6. Sex 1 1 1 1 1 2	Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea Feb. 19,1		
	and sw		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town o	Location		10d. Inside City Limits	
	Mary a-f sh	ctor	MD Montgomery	Gaithersburg		1 □Yes 2 No	
	ith the	Dire	10e. Street and Number	10f. Zip Code 20877		Citizen of What Country? nited States	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy highry or other traumatic event, the Midrial Event has real by notified at once.	y Funeral Director	1 Ä Never Married 2 Married 1 ∏Yes 2 Ä No If Yes, Give	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.  Specify: White	
21215-0036	in 72 houn n "natural" Nedical Ex	Completed by	15. Decedent's Education 16a. D (Specify only highest grade completed)	ecedent's Usual Occupation five kind of work done during most of work te. DO NOT use retired)	ing	Kind of Business/Industry	
212	d with giene	mo.	Elementary/Secondary (0-12) College (1-4or 5+) "	Tree expert		Tree Service	
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	Be	17. Father's Name (First, Middle, Last) Herbert T. Myers		e (First, Middle, Maid Jorraine ()		
aryl	should nd Me mark	은		ailing Address (Street and Number or Rui		•	
	1 and 2 Health a em 27 Is ether tra			Rolling Road, Gait			
Baltimore,	permit. Pages 1 Department of H Important: If Iter any Injury or oth		20a. Method of Disposition  1 № Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of D Park Law Cemeter	m Memoriai <sup>P</sup> P. Sept	ember R	Location - City or Town, State	
Ball	Departition Departition Departition Departies and Incompany Incomp		21. Signature of Funeral Service Licenses  RACY  TUITI	22. Name and Address of Facility DeVol Funeral Home Gaithersburg,	10 East MD 20877	Deer Park Drive,	
	ificate be executed  Medical Examiner  State burial-transit	al Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)	an cer		Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medical	d.  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
ds,	ires the signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 □ No 3 □ Probably 4 ☑ Unknown	
of Vital Records,	hysician: The law requir this certificate has been s il director, page 2 should I	Completed			24a. Was an autopsy performed 1 ∐Yes 2 🌠	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No	
/ita	Physician: r this certific ral director, p	Be C	25. Was case referred to medical examiner?		th (Check only one)		
on of \	ding P	tion: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  1 Inpatient 2 ER/Outp  28a. Date of Injury (Month, Day, Year)  28b. Tin	ne of 28c. Injury at	ome 5 1 Residence 28d. Describe how in	e 6 □Other (Specify) njury occurred	
Division	al or Attendi safter death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.				
	Vithi Vott	Ň	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)	
	5		P/tang 16 Wille MO	D55258	5 6	Newber 2, 2008	
			30. Name and address of person who completed cause of death (Item 23a) (To Tavy Wilks, MD (2095 Marshales	Drive Elkride.	, mp 2	1075	
	Sta Registr		31. Date filed (Month Perp Year) 4 2008 32. Registrar's Signature	pare			

		1 - For State Registrar	State of Ma	-	ertificate of I			leg. No. $2$	008	300	152
Physic		Decedent's Name (First, Middle, L     Will	ast) .iam Thomas Mc	Vicker			2. Date of Dea Month <b>August</b>	Day 31	Year 2008	3. Time of D 8:00	
/Med Exami		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death		4c. Cour	nty of Death		
		Manor Care Po	otomac		P	otomac			Mont	gomery	
Funeral Director			Sex 7. Age	76 (In yrs. last birthda 76	Months I Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day August 2	, Year)	Coun	lace (State or etry) W Jersey	_
nyland show	_	10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City	
e Ma 3a-f s	cs	Maryland Montg	gomery		R	kockville					- 20 140
or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen d	of What Cour		
ath w	ā	14208 Oakvale St				20853		144 🖪	U.S.		
be filed within 72 hours after death with the Maryland Ital Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ▼ Yes 2 □ N If Yes, Give	lo	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> <li>1 ☐ Yes 2 No</li> </ol>		ecity Yes or No- Rican, etc.)	Spe	Race - Americ Black, White, cify:	etc.	
hours tural"	ed by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's I	Year or Dates:1		cedent's Usual Occup	ation		16b. Kind of	Business/Inc	White	_
in 72 n "na fedic	Completed	(Specify only highest g	ade completed)	(G	ive kind of work done one. DO NOT use retired	during most of work	king	100.74.10	D4011/030/11	add.ry	
with jiene. r thar the N	l w	Elementary/Secondary (0-12)	College (1-4or 5- <b>4</b>	+)	Inspect	or			FDA		
other sent, th	Be C	17. Father's Name (First, Middle, Las	t)		-	18. Mother's Nam	e (First, Middle,	Maiden Surn	ame)		
ould be f Mental F arked ol	일 문	Harold McVi	eker			C	atherine H	liggins			
and and sum	1.	19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	ailing Address (Street	and Number or Ru	ral Route Numbe	r, City or Tov	vn, State, Zip	Code)	
1 and Health em 27		Mark McVicker - Se	on		907 Osprey Wa						
Page nent o int: If	1	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		cemetery, o	sposition (Name of crematory or other place <b>Heaven Cemet</b> e	ce)	Date 5/2008		on - City or To	own, State <b>, Maryla</b> :	nd
permit. Departn Importa any Inju		21. Signature of Funeral Service Lice	Luden	ra	22. Name and Addre Hines-Rinald 11800 New Ha	i Funeral	Home, Inc.	er Spri	ne. Mar	vland 20	904
rificate be executed  Exam  g physician and as the burial-transit		disease or condition resulting in death)  Sequentially list conditions, if any, leading to intrinsulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):	ne he	patibis					
The law requires that the death certifics ate has been signed by the attending propage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify) □	4			Date of delive Month	*	ear	
uires that signed by d be deta	b	Part II. Other significant conditions	contributing to death bu	ut not resulting in th	e underlying cause giv	en in Part I.	23e. Did to			he cause of de bably 4. <b>⊠</b> Ui	
The law require has been bage 2 should	Completed						1□ Yes	rmed? 252 No	b. Were auto prior to co death? 1 □ Yes	opsy findings a mpletion of ca	vailat use o
sicla s certi irecto	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpa	tient 3 DOA Oth	er: 4 M Nursing H	ome 5 Resid		Other (Case)	6.1	
ding P J. After t funera	ion: To	27. Manner of Death 1.★Natural 5 Pending	28a. Date of Injur (Month, Day	ry 28b. Tim	e of 28c. Injui	-	28d. Describe h		<u>``</u>	(y)	
or Atter frer dea irector in by the	Certification:	3 Suicide 6 Could not	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office					Street and Nu vn, State)	mber or Run	al Route Numb	er,
e Hospital 24 hours a E Funeral etely filled	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examination and/o							1
To the Ywithin 2 To the complete	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sig	gned (Month,	Day, Year)	
579		×	<i>//.</i>		Doo	54566		9/11	08		
		30. Name and address of person who Sunitha Bhog	avilli, 980	1 Cheon		nue #1-	17, 5;	lvers	prin	1002	LCC
Si Regis	tate trar	31. Date filed (Month Pap Year)	2008 32. Red stra	ar's Signature	Society )				•	')	

Phy:	siciar edica mine
Exa	eaica min <u>e</u>
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
	00

			partment of Health and Mertificate of Death		2008 30053
Physiciar /Medica	n	Decedent's Name (First, Middle, Last)  Carla Joan Miles		2. Date of Death	Day Year 10:20 AM
Examine	r	4a. Facility Name (If not institution, give street and number)  Anne Arundel Medical Center	4b. City, Town, or Location of Death  Annapolis		4c. County of Death  Anne Arundel
uneral rector		5. Social Security Number  6. Sex 1 M XX F  7. Age (In yrs. last birthde) 6. Sex 1 M XX F  7. Age (In yrs. last birthde) 6. Sex 1 M XX F  7. Sex 1 M XX F  8. S	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Sept 8, 1	ear) 9. Birthplace (State or Foreign Country) California
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Do Commission by Europea Disperse	ctor	10a. State 10b. County 10c. City, Town or I	nnapolis	10g	10d. Inside City Limits  1 □ Yes → → → → → → → → → → → → → → → → → → →
er must be	<u>a</u>	2723 Lury Lane  11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	21401  Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo	U	nited States  14. Race - American Indian, Black, White, etc.
itural", or it al Examin	ਨੂ	1 ☐ Never Married 2	1 ☐ Yes 2 【 No Specify:  edent's Usual Occupation		Specify: White
the Medic	Completed	(Specify only highest grade completed)   (Giv	e kind of work done during most of work DO NOT use retired) Homemaker	ing	Own Home
narked other natic event	10 Be	17. Father's Name (First, Middle, Last) William F. Sclotter	Gladys H	. Etterbe	ek
em 27 Is nother traum	-	Richard J. Miles / Husband 2723	ling Address (Street and Number or Run  Lury Lane Annapo  position (Name of	lis, Mary	
ortant: If It Injury or c		1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimor	ematory or other place) e Crematory 9/3/2	2008 Ba	ltimore, Maryland lor Funeral Home,In
Impor any Ir once.		Server I I of	147 Duke of Glouce	ster St.	Annapolis, MD 21401
physician and sthe burial-transit succession and sthe burial-transit successions.	dicai Examiner	Immediate Cause (Final disease or conditions resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):	Canle		Onset and Death
y the attending sched for use a			□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
be d	2	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
ate has		25. Was once referred to medical			24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
After this funeral d	0	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 2 Set. Time Injury  27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury (Month, Day Year) Injury 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)	of 28c. Injury at Work?  M 1 Yes 2 No	me 5 ☐ Residenc 28d. Describe how	et and Number or Rural Route Number,
To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, der 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
		29b. Signature and title of certifier  Centur Harring ML	29c. License number 0 5 3 3 0 6		Date signed (Month, Day, Year)
State Registrar	e	30. Name and address of person who completed cause of death (liem 23a) (Type Curff's Harr's M) 900 3 Stages 31. Date filed (Month, Day, Year) 32. Relistrar's Signature SEP 0 3 2008	Roal Spe 300	, Anna	9/1/28 nolis MO2142

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 1,2008 **Physician** T. Moore Angela 2:20p M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Fulton Montclaire Manor Inc. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 / 2 1 / 19 1 2 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Washington, DC 95 579-07-7661 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County er than "natural", or items 23a or 28a-f show the Medical Exeminar must be retified at 10a. State MD Howard Clarksville 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 220 any injury or other traumation. 21029 USA 12926 Kentbury Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: ò 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 School Cafeteria Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Briganti Fortunata Gioffre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12926 Kentbury Dr. Clarksville, MD 21029 Joan Davis Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 9/5/2008 Clinton, MD Burial 2 Cremation 3 Removal from State Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Rome, P.A. 21. Signature of Funeral Service Licensee 0 Annapolis, MD 21401 12 Ridgely Ave. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to wr as a conse juence of) Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed g physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No Ö 9 Unknown 9 Unknown ۳. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔼 filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specification home) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attending Fafter death. Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Elizabeth Bower, M.D. Wood stock 10711 Birmingham Wan 31. Date filed (Month, Day, Year) SEP 0 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 🚄 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 09 10:00 PM 01 B. MERCER WILLIAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL ANNE ALUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug. 12, 1 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1**№** M 2□ F Months 1924 West Virginia 235-34-2788 Director 84 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 ☑ No Director Anne Arundel Annapolis MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21409 1325 Cape St. Claire Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 212 No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 Is marked other than 'ury or other traumatic event, Items College (1-4or 5+) Elementary/Secondary (0-12) Department of Defense Research Chemist  $5 \pm$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Burtis Schooley Arza Fountain Thomas Mercer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1325 Cape St. Claire Road Annapolis, MD 21409 Doris C. Mercer/Wife permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tr once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Sept. 6, 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signifure Funeral Servicy Licens 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 art 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shoo, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resetting in death) 12 HOURS ACUTE MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a 9 Unknown Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown HODGKINS LYMPHOMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes **Division of Vital** 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t or Attending 5 Pending investigation Natural Natural 1 ☐ Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. To the I 29b. Signature apo D66753

DHMH 17 Rev 1/2001

0 3 2008 Registrar

Year)

Medical Parkway, Annapolis MD 21401 Capstack ALK MO, 2001 32. Jegistrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

		-	State of Maryland / Department of Health and   State   State   Amended#26perMD   FCHD, KS   9/4@Stificate of Death		711110	30056
				Reg.	No.	3. Time of Death
	Physicia	ın İ	1. Decedent's Name (First, Middle, Last)	Month I	Day Year	
	/Medic		Charles Kemp Norwood II	1===0	7 2008 4c. County of Deat	6:43p
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	atri	,	_
	۔ مدرین		6120 Woodville Road Mt. Airy  5 Social Security Number	s. 8. Date of Birth		erick hplace (State or Foreign
	Funeral		1 M 2 F	1. (Month, Day, Ye	ar) Co	untry)
£	Director		220-16-0606   184   83   Yrs.   Usual Residence of Decedent	Aug. 5,19	25 M	aryland
	pue »	}	10a, State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	faryl sho ed at	5				1 ☐ Yes 2 No
	the N 28a-1 notifi	Director	Maryland Frederick Mt. Airy  10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	ountry?
	with a or be r				II i to 3	Ctatos
	sath	eral	6120 Woodville Road 21771  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	United 14. Race - Ame	
	item item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☒ Married  1 ☒ Yes 2 □ No	erto Rican, etc.)	Black, Whit	e, etc.
36	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by	If Yes, Give 1 ☐ Yes 25 No Specify:  3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1945–58		Specify:	White
3	hou Itura	ᄝ	15 Decedent's Education 16a Decedent's Lisual Occupation	16b	. Kind of Business	
Ċ	within 72 ene. than "nai he Medic	Completed	(Specify only highest grade completed) (Give kind of work done during most of w	vorking		
7	with iene. thar	E	Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Clerk	U.	S. Post	Office
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aŭ	d be ental ced o	Be C	Charles K. Norwood Sr. Hattie	Rimbev		
Maryland 21215-0036	2 should and Mer is marke aumatic	ဍ	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or a		ty or Town, State,	Zip Code)
<u>N</u>	d2s than 7 is i		Shirley Norwood/ Wife 6120 Woodville Road,			
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		. Location - City or	
ŏ			1 🖾 Burial 2 🗆 Cremation 3 🗀 Hemoval from State	. ,		
<u> </u>	t. Pa tmer tant: tant:			1/2008   Mt	. Airy,	Maryland
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature Fineral Senter Donne 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown	Homes P. A. Pike, Frede	rick, Ma	ryland 21702
	- 11		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	liac or respiratory arrest,		Approximate Interval Between
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l s	, 4. 微 第	ē	Sequentially list conditions.			
	uted Insit	Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events)  TERMINAL PINKKINSIN'S DISKINSE	,		
	execu and ai-tra	Xa	resulting in death) Last  Due to (or as a consequence of):			
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28	ficate phy s the	g	U.	_	I la company	
×	death certific attending p	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant  23c. If yes, outcome pf pregnancy		23d. Date of de	elivery
m	eath atter for u	ciar	in the past 12 months?		Month	Day Year
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ds,	signed	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute	
ords,	requires the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_ 1 ☐ Yes	2 No 3 F	Probably 4 Unknown
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 1ACCIACIST /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Maryland Med Year If Under 24 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 DXF Months Days Hours 160-28-2397 8/1/1934 Director 74 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventines must be notified at 1 ☐ Yes 2X No Director KENT ROCK HALL MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5642 WALNUTS ST 21661 Funeral 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: Specify ģ WHITE 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **HEALTHCARE** REGISTERED NURSE is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET TUDOR WARREN EDWIN BOTDORF 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 5642 WALNUTS ST. ROCK HALL, MD 21661 BRIAN NESSPOR/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 9/6/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEÉR RD. CHESTERTOWN, MD 21620 23a. Prt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dee to (or as a consequence of) law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day for 5 Other (specify) □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes page 2 certificate 1 ∏Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 2 | 2 | 2 | 2 | 3 | 3 | 1 patient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Box 68760, Division of Vital Records, completely To the I within 2 **To th**e

State Registrar

31. Date filed (Month, Day, Year)

nd address of person and completed cause of death (Item 23a) (Type, Print)

Greene St. Baltimore MD 21201 TSIKARIS MD Aviel 32. Registrar's Signature

2008

**ORIGINAL** 

		State Registrar Amended		rfH,#Zpe	rMDCe	artment of F rtificate of	Death			08 31,∕20	3. Time of Death
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xamin		4a. Facility Name (If not institution,	give street and nu			4b. City, Town, o	r Location	of Death		County of Dea	
		Northampton Ma				Freder	ick If Under	24 Hrs. 8. Date of	Dieth		derick
neral ector		5. Social Security Number 214–28–6856	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. Ia		Months Days	Hours	Min. Feb.	Day, Year) 5, 19	31 Wes	irthplace <i>(Stat</i> e o <i>r Foreign</i> So <i>untry)</i> St Virginia
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any injury or other traumatic event, the Medical Examiner must <u>be notified at once.</u>		21. Signature of Funeral Service I	icaheaa		2	Name and Addre	es of Facili				
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should be defached for use as the bunal-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes  No 9 Unknown	1 ☐Live	utcome pf pregnal birth 2 Petal gnant at time of de nown	death 3	⊒Ectopic pregnanc ☐ Other <i>(specify)</i> _	<i>y</i>		- 1	23d. Date of d Month	elivery Day Year
deta		Part II. Other significant condition	ns contributing to o	death but not resu	Iting in the u	nderlying cause giv	en in Part	. 23e. D	id tobacco u	se contribute	to the cause of death?
should be	ed by							1	☐ Yes 2	<b>₹</b> No 3□	Probably 4 ☐ Unknown
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bac	E S							p 1□ Ye	erformed?	death′ 1 ☐ Ye	?
ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			104	**	e of Death (Check or	ly one)		
ral dir	.T	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 E	ER/Outpatier 28b. Time o		4 X N	ursing Home 5 F	desidence be how injur		pecify)
completely filled in by the funeral director, page 2 should be detached for use as the bunat-transit	ition	1 Natural 5 Pending investig	(Moi	nth, Day Year)	Injury	Wor	k? Yes 2 🗍		be now injui	y occurred	
in by th	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 26e. Plac	e of injury - At hording, etc. (Specify	me, farm, st	reet, factory, office			n (Street an Town, State		Rural Route Number,
completely filled in by the	edical C		xaminer: On the					nd place, and due to ath occurred at the ti			
сошр	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Dat	e signed (Mo.	nth, Day, Year)
1		IAN				D 0	0516	43	Sept	ember	2, 2008
1		30. Name and address of person	vho completed cau	use of death (Item	23a) (Type,	Print)					, , , , , , , , , , , , , , , , , , ,
/	1										
/ / Sta		Hiren Shah, 31. Date filed (Month, Day, Year)	M.D. 6 4 2008	5-C The	omas	<u>Johnson</u>	Dr.	, Freder	ick,	MD 21	702

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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			For State AMEND#19aperINF  1. Decedent's Name (First, Middle, Last)	State of Maryland, 9-9-08, EMW, MoCo	d / Depa <i>Cer</i>			ealth ar Death			ene/ ( g. No.	JU8	3 () ()	5 9
	Physici /Medic		Jean M. Plass	-					S	eptember			5:10A.	М
	Examin	er	4a. Facility Name (If not institution, give s Manor Care	treet and number)				Location of Spring				on tgo:		
F	Funeral Director		2,0 20 2,00	7. Age (In yrs.)	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	4 Hrs. 8 Min.	B. Date of Birth Month Day May 20, 1	922	9. Birth Was	place (State or Fo intry) hington,	oreign DC
	Maryland a-f ahow	ctor	Usual Residence of Decedent  10a. State  Maryland  Prince Ge		, Town or Lo								10d. Inside City L	
	with the	I Director	10e. Street and Number 5011 Muskogee Stre	et		10f. Zi	p Code 20 <b>7</b> 4	0		10		ed St		
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23e or 28e-f ahow importants if item 27 is marked other than "natural", or items 25e or 28e-f ahow my ortally or other traumatic avent, it is Medical Experimental be rediffied at 2006.	by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 (M)No If Yes, Give Year or Dates:		Was Dece f Yes, spo 1 Yes	ecify Cuba	ispanic Origi In, Mexican, Specify:	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		lack, White	ncan Indian, o, etc. hite	
Maryland 21215-0036	within 72 ho lene. than "natur te Medical I	Completed	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. I	kind of w DO NOT I	ork done o use retired	during most o f)	of working	9		Business/I	ndustry Commerce	
land z	ould be filed Mental Hygi arked other atic avent, I	To Be C	17. Father's Name (First, Middle, Last) Nicholas J. Plass						,	(First, Middle, M		ame)		
	1 and 2 shou Heelth and M Ism 27 is mar		19a Informati's Name/Relationship (Ty, Mary Petrone –Nied Mary Patrone –Nied	pe, Print) CE						Route Number.			ip Code) and 2074	<del>'</del> +O
Baltimore,	Pages 1 and nent of He Int: If Itam		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		lace of Dispo emetery, crer popoli	natory or	other place	atory	Da 9/3/				rown, State Virgini	ia
Balti	permit. Page Depertment Important: It any injury o		21. Signature of Forth ral Service License	and I	D6	Name a ona I c 400 I	owde	Borgwa Borgwa r Mill	erdt L Roa	Funeral d Belts	Home	, PA , Mar	yland207	<b>7</b> 05
ý	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Finaf disease or condition resulting in death)	cations that caused the deatle cause on each line.  END STA  Due to (or as a conseq	4E		de of dyin				st,	sE	Approximate Interval Betwee Onset and Dea	
8760,	cate be executed physicien and it the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	HEAR	Т	FAIL	UR	( <del>-</del>			**************************************	#h5
9	The law requires that the death certific ste has been signed by the ettending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	3c. ff yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	fdeath 3	Ectopic   Other (s	oregnancy	·			23d.	Date of defi Month	ivery Day Yea	ar
ds, P.	juires that n signed by ild be deta	ρ	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying	cause giv	en in Part I.			acco use d		the cause of dea	
Division of Vital Records, P.O. Box		Completed						-		24a. Was ar autops perform 1 Yes 2	/	b. Were au prior to death? 1 \sum Yes	stopsy findings ava completion of cause	allable use of
<u> </u>	scertificate director, pag	o Be	25. Was case referred to medical examiner?	lospital: 1   Inpatient 2	ER/Outpatier	nt 3 🗆 🗆	Oth Oth			(Check only one		Other /Soe	cify)	
ion oi	Attending Physician: or death. ector: After this certifice by the funeral director.	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)	28b. Time o Injury		28c. fnjur Wor		21	8d. Describe ho			ony,	
Divis	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the control of	ome, farm, sti (y)	reet, facto	ry, office		2	8f. Location (St. City or Town		ımber or Ru	ural Route Numbe	эг,
	a Hospi 24 hour Funar etely filk	Medical (	29a. Certifier Check only one) Certifying Physical Exami	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the tir	me, date and pinion, death	i place, a h occurre	nd due to the ca d at the time, da	use(s) and ite and pla	manner as	s stated. to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier			2	9c. Licens	e number		25	9d. Date si	gned (Mont	h, Day, Year)	
)	10		30. Name and address of person who co	4	n 23a) (Type.	Print)	D	-172	874	4	9-	5-51	508	
		110	5 · M · NAY AR  31. Date filed (Month, Day, Year)	MD 37	7 - sture	3815	AVG	COT	TAG	ie cit	4,	MD	20722	<u></u>
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			State of Maryland / Dep		•		000	30060
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Sadie Plante		2. Date of D Month Augus	Day	Year 2008	3. Time of Death
	Funeral Director	er	4a. Facility Name (If not institution, give street and number)  Washington Adventist Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda, 1 m 2	Months Days Hours		irth Day, Year)	22 Mass	
	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If firem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a firedical Executes must be notified at once.	ral Director	Maryland Montgomery Silve 10e. Street and Number 11621 New Hampshire Avenue, #322	r Spring   10f. Zip Code   20904		10g. Citi	izen of What Cou	1 □Yes 2 🙀 No
2-0030	nours after dee ural", or items	d by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origing If Yes, specify Cuban, Mexican, In Ingress 2 ☑ No Specify:	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Amer Black, White, Specify:	white
-61717	ed within 72 h lygiene. her than "nat ht, ir e l'edic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Ho	edent's Usual Occupation we kind of work done during most of DO NOT use retired) memaker		Own	Home	ndustry
ıryıand	should be fi nd Mental F marked ot imatic ever	To Be	17. Father's Name (First, Middle, Last) Peter Klassanos  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Ka	s Name (First, Middle  atherine E  or Bural Boute Num	Bavel	as	in Code)
re, ma	s 1 and 2 s of Health ar item 27 is other trau		20a. Method of Disposition 20b. Place of Discomplant of Company of	ling Address (Street and Number 315 Tamworth Lar	Date		, MD 209	
baillimor	permit. Page Department of Important: If any Injury or once.	8	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	itan Crematory  22. Name and Address of Facility Francis J. Coll: 500 University H	Sept. 3, 2008 ins Funera 31vd, W.,	l Ho	andria,\ me Inc. er Sprin	_
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (ir as a consequence of):					Approximate Interval Between Onset and Death
	be executed many incident and purial-transit	Examiner	Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Just to (of as a consequence of):  Due to (of as a consequence of):	demis .				
0/00 X	eath certificate be executed attending physician and for use as the burial-transit	/Medical	IF FEMALE:	Chem.		1		
.O. DOX	the death or the attention of the attention of the attention of the attention of the use	Physician/Medi		☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
cords, r	equires that en signed to	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			use contribute to ☐ No 3 ☐ Pro	the cause of death?
אוומו שבכנ	To the hospital of Attending Priystcian; The law requires that the death certificate within 24 starter death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	Completed	OF Who are referred to medical		per 1 □ Yes	opsy formed? 2 No	prior to c death?	topsy findings available ompletion of cause of
5	s cert lirecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Other:	of Death (Check only		0 DO# (0	
	nding Pnyath. r: After this re funeral c	l⊢∃	27. Manner of Death    Xatural   5   Pending   2   Accident   28a. Date of Injury   28b. Time   28b. T	of 28c. Injury at	28d. Describe			eny)
בואום	ital or Arte irs after de ral Directo led in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, suitiding, etc. (Specify)	street, factory, office	28f. Location City or To	(Street and Swn, State	nd Number or Ru e)	ral Route Number,
	une nusp hin 24 hou the Funel npletely fil	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de   Check only one)  Medical Examiner: On the basis of examination and/or  and manner stated.	investigation, in my opinion, death	place, and due to the occurred at the time	e, date and	d place, and due	to the cause(s)
Í	© <b>1</b> ₹ <b>2</b>	_	29b. Signature and title of certifier	29c. License number	39	29d. Da	te signed (Month	i, ∪ay, rear)
•	16		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	·		100	
	Sta	to	Padma Chirumamilla, MD 7600 Carro 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	oll Avenue, Tako	oma Park,	MD 2	0912	

State Registrar

31. Date filed (Month, Day, Year)
SEP - 4 2008

State of Maryland / Department of Health and Mental Hygiene 108 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 7:46 aM 01 2008 September Roman Petrenko /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Ashton 137 Crystal Spring Drive 9. Birthplace (State or Foreign Country) Ukraine If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**⊠** M 2□ F Yrs. 94 December 13, 1913 073-26-2303 Director Usual Residence of Decedent with the Maryland 10d. fnside City Limits 10a. State 10b. County 10c. City, Town or Location ral, or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 ▼ No Ashton Maryland Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20861 137 Crystal Spring Drive Pages 1 end 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced White "natural" the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Library of Congress Librarian 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I (Unknown) 2 Arseney Petrenko Tetvana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth in Item 27 I 137 Crystal Spring Drive, Ashton, Maryland 20861 Jurij Petrenko - Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot once. St. Andrew's Ukrainian 1 Burial 2 ☐ Cremation 3 Removal from State 09/04/2008 South Bound Brook, NJ 4 ☐ Donation 5 ☐ Other (Specify) Orthodox Cemetery 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate fnterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. The conditions (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed inding physicien and use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 90 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been si rector, pege 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🕱 No SIL After this funeral of 28c. Injury at Work? Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct 4 | Homicide 29a. Certifier 1 🕱 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) September 2, 2008 D0064615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month Day, Year)

Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850

32. Aegistrar's Signature

ASIAN.

30062

Physic	ian
/Medi	ca
Exami	nei

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, if a Proficel Exercite or must be notified at any Injury or other traumatic event, if a Proficel Exercite or must be notified at any once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

Registrar

	1 - State Registrar		Certi	ficate of L	Re	Reg. No.				
	1. Decedent's Name (First, Middle, Last)		2. Date of I Month					Year 3	3. Time of D	Death
ian cal	Anthony	F.		Prenci	pe	August 3	31,2008		8:48	$\operatorname{am}^{M}$
ner	4a. Facility Name (If not institution, give s	street and number)	4	b. City, Town, or	Location of Death		4c. County of	Death		
	8608 Fluttering Le	eaf Trail		0denton			Anne A	runde	1	
	5. Social Security Number 6. Sex		1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthplace Country CN	e (State or	Foreign
	5/8-44-1843	JM 2LJF 73	Yrs.			771 I71	935	CN		
7	Usual Residence of Decedent  10a, State 10b, County	10c City T	own or Loca	tion				10d	Inside City	v Limits
5	MD Anne Aru		OWITOT LOCA	0den	ton				1 □Yes	
ecto						1				
Funeral Director	10e. Street and Number 8608 Fluttering	Leaf Trail #30	5	10f, Zip Code	21113	10	ng. Citizen of Wh USA		ř.	
ral										
I n	11. Walta States	12, Was Decedent Ever in U.S. Armed Forces?		is Decedent of Hi es, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		<ul> <li>American</li> <li>White, etc.</li> </ul>		
N N	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 GYes 2□No 1954	1 1 L	]Yes 2⊠No	Specify:		Specify:	W	hite	
Completed by		Year or Dates: 1962		nt's Usual Occupa	otion		16b. Kind of Busi	innee/Indust	tru	
Set	15. Decedent's Educ (Specify only highest grade	e completed)	(Give kir	nd of work done of NOT use retired	lurina most of work	ing	100. Killa ol Dasi	111633/111003	.i y	
Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	Maile		,		Washing	ton P	ost	
ŭ	17. Father's Name (First, Middle, Last)	+	11411		18. Mother's Name	e (First, Middle, N				
Be C	Michelino Prencipe	2			Rosina	Gallucci				
2	19a. Informant's Name/Relationship (Ty)		10h Mailing	Address (Street :	and Number or Rur			tate Zin Co	nde)	
	Mary Jane Prencipe	' ' I			g Leaf Tr			iaio, zip oo	00)	
	20a. Method of Disposition						20c. Location - C	ity or Town.	. State	
	1 kg Burial 2 ☐ Cremation 3 ☐ R			ion (Name of tory or other place	ery 9/4/		Crownsvi			
	4 □ Donation 5 □ Other (Specify)				ery   9/4/	I .		•		
	21. Signature of Funeral Service License	7	- 1		Ave. An	•		-	F • A •	
	23a. Part 1. Enter the disease, or compli	cations that caused the death.	-1					A	proximate	
	shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		1	41-			Or	terval Betw nset and D	reen eath
	disease or condition resulting in death)	Howar	cea		2009	and	UY	8	100x	TH
		Due to (or as a consequen	ice of):							
<u></u>	Sequentially list conditions,	. Due to (or as a nonsequen	es off:					_		
Ë	Sequentially list conditions, if any, leading to in module cause. Enter Underlying Cause (Disease or injury that initiated events	Silo to for on a torner, necessity						1		
xar	that initiated events resulting in death) Last	Due to (or as a consequen	ice of):							
Medical Examiner										
gi	d						-			
	IF FEMALE:	3c. If yes, outcome of pregnancy	v				and Date	of dollars.		
ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	eath 3∐E	ctopic pregnancy	У		23d. Date Mont	of delivery th Da	ıy Y	'ear
ysic	1 ☐Yes 2 ☐No 9 ☐ Unknown	9 Unknown	ui 5 🗆 (	Other (specify)						
by Physician	Part II. Other significant conditions con	ntributing to death but not resulting	na in the und	erlying cause give	en in Part I.	23e. Did tob	acco use contrib	oute to the o	cause of de	eath?
l by				, ,		1 X Ye	s 2 □ No 3	3 ☐ Probabl	v 4 🗆 U	Inknown
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Id I						24a. Was ar autops	y pr	ere autopsy ior to compleath?	findings a letion of ca	wallable luse of
Ö						perform 1 🗆 Yes 2		Yes 2	□No	
Be	25. Was case referred to medical examiner?	lospital:		Tout-	26. Place of Deat	h (Check only one	θ) \			
2	I Tes 2 140	1 ☐ Inpatient 2 ☐ ER			4 LI Nursing no		nce 6 Other			
O	27. Manner of Death 1 Pending	28a. Date of Injury (Month, Day, Year)	Bb. Time of Injury	28c. Injury Work		28d. Describe ho	w injury occurred	d		
cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No					
E	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	t, factory, office		28f. Location (St. City or Town	reet and Number n, State)	r or Rural R	oute Numb	oer,
Medical Certification: To										
ca	(Check only 2 Medical Examin	sician: To the best of my knowle ner: On the basis of examination	edge, death o n and/or inve	occurred at the tir stigation, in my o	ne, date and place, pinion, death occur	, and due to the c red at the time, d	ause(s) and mar ate and place, ar	ner as state nd due to th	ed. e cause(s)	)
led	one)	and manner stated.								1
3	29b. Signature and title of certifier	- 11	人人	29c. License	e number		9d. Date signed	(Month, Da)	/, Year)	2.7
y	10 mgh		1/0	4	1) 390	41 21	EME	1 A B F	-K 2	1008
	30. Name and address of person who co	mpleted cause of death (Item 23	3a) (Type, Pr	int) 300	1 5.	Har	LOVES	5	ho	es
	GAYARI M	MMAGANN	4	B-	かん	re	MD	215	225	
ate	31. Date filed (Month, Day, Year)	32. egistrar's Signature								

# ■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

hysicia		State Registrar  1. Decedent's Nam	e (First, Middle. L	ast)		Cen	ificate	טוט		2. Date of Dea			3. Time of Death
/edica			er V. Po							Month August	31		2:00 A
ımine		4a. Facility Name (	If not institution, g	ive street and number)			4b. City, T	own, or L	ocation of Death		40	. County of Death	
				Hospice Ho	use			nthi				Anne Arui	
eral		5. Social Security N 079-03-3			e (In yrs. las 38	t birthday) Yrs.	If Under 1 Months	Year Days	Hours Min.	8. Date of Birt (Month, Da	h y, Year	9. Birth	nplace (State or Fore untry)
tor		Usual Residence of								Jan. 2	4,19	920 Oh:	10
H		10a. State	10b. County	undal		Town or Loca	_						10d. Inside City Lim
Selline.	ecto	MD	Anne Ar	mider	sev	erna I							1 □ Yes 2 □
any injury or other traumatic event, the medical Evaluation at once.	Funeral Director	715 Ben	mber field Ro	ad			10f. Zip (	1146				itizen of What Cou JSA	untry?
100	nuel	11. Marital Status		12. Was Decedent Armed Forces?		13. W	as Dec <i>e</i> de Yes, speci	nt of Hisp y Cuban,	panic Origin? (Sp Mexican, Puerto	pecify Yes or No Rican, etc.)	.	14. Race - Amer Black, White	
SE SE	by F	1 ☐ Never Mari	ried 2 Married	ii yes, Give	WWII	1	□Yes 2	No	Specify:			_	hite
53 E3	edk	3 🗆 Widowed	15. Decedent's	Year or Dates:	- 1	16a. Decede	ent's Usual	Occupati	on		16b. H	Kind of Business/I	ndustry
Wade	Completed	(Spe	cify only highest g	rade completed) College (1-4or l		(Give ki life. Di	ind of work O NOT use	done du retired)	ring most of worl	- 1			,
	E O	Liementary/3ect	oridary (0°12)	<b>4</b>	) <sup>+</sup> / C	ertifi	ied P	ublio	Accoun	tant	Aı	nstar Co	rp.
yent	Be (	17. Father's Name	(First, Middle, La:	st)				1	8. Mother's Nam	e (First, Middle,	Maide	n Surname)	
	၉	unk							Anna Ko	pec			
rani		19a. Informant's N	· .			_						or Town, State, Z	
	4 4			Daughter	Look Dis							es, CA 9	
5		20a. Method of Dis 1 ☐ Burial 2	Cremation 3	☐ RemovaL from State	20b. Plac	e of Disposi netery, crema	tion (Name atory or oth	e of er place)	nc. Sept	Date 02		ocation - City or I	· ·
<u>n</u>		4 ☐ Donation	5 ☐ Other (Spec	cify)	Metr	o crei	lacor	γ, 1	2	008		<del>*</del>	Maryland
any In		21. Signature of	uneral Service Uc	ensee	20.0	) Bai	Name and	Address	Sons, P.	A. Seve	rna	Park Fur Park, M	neral Hom
ical iner	iner	disease of conditi- resulting in death)  Sequentially list co- if any, leading to in cause. Enter Unde Cause (Disease on that initiated event		Due to (or as	a consequer	nce of):			U C C	rider			
悥	dical Examiner	that initiated event resulting in death)	s Last	cDue to (or as	a consequer	nce of):							
	Physician/Medica	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	! months? □ No	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal de	eath 3 🗌	Ectopic pre Other (spe					23d. Date of deli Month	ivery Day Year
5		Part II. Other/signi	ficant conditions	contributing to death b	ut not resultin	ng in the und	derlying car	use given	in Part I.	23e. Did t	obacco	use contribute to	the cause of death
d delacie	_	de	nent	1a						1 🗆 1	es 2	2 □ No 3 □ Pr	obably 4 Unknow
9	ed by									24a. Was		24b. Were au	topsy findings availa
9	pleted by												
D D D D D D D D D D D D D D D D D D D	ompleted by									autop perfo	rmed?	death?	completion of cause
	Completed	25. Was case refe	rred to medical						26. Place of Dea	autor	rmed?	death?	completion of cause
	Be Completed	25. Was case refe examiner? 1 □ Yes 2		Hospital: 1 ☐ Inpati	ent 2 EF	3/Outpatient	3 🗆 DOA	Other		autop perfo 1 □ Yes th <i>(Check only o</i>	rmed? 2 A ne)	death? o 1 ☐ Yes	completion of cause 2 □ No
	To Be Completed	examiner? 1 ☐ Yes 2 ☐ 27. Manner of Dea	luo th	Hospital: 1 ☐ Inpati	ırv 28	3/Outpatient 8b. Time of Injury		Other	4 ☐ Nursing H	autop perfo 1 □ Yes th <i>(Check only o</i>	rmed? 2 (1) nne) dence	death? o 1 □ Yes  6 □ Other (Spec	completion of cause
	To Be Completed	examiner? 1 Yes 2 27. Manner of Dea 1 Natural 2 Accident	th 5 Pending investigati	28a. Date of Inju (Month, Da	ırv 28	8b. Time of		Other c. Injury a Work?	4 ☐ Nursing H	autop perfo 1 □ Yes th <i>(Check only c</i> ome 5 □ Resid	rmed? 2 (1) nne) dence	death? o 1 □ Yes  6 □ Other (Spec	completion of cause 2 □ No
D D D D D D D D D D D D D D D D D D D	To Be Completed	examiner? 1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☐ Natural	th 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry 28 y, Year)	8b. Time of Injury	M 28	Other c. Injury a Work? 1 □ Ye	4 ☐ Nursing H at	auto; perfo 1 □ Yes  th (Check only come 5 □ Resident 28d. Describe I	nne) dence now inju	death? 1 □ Yes  6 Dother (Spec	completion of cause 2 □ No
nan ninous z	Certification: To Be Completed	examiner? 1 Yes 2 27. Manner of Dea 1 Natural 2 Accident 3 Suicide	th 5   Pending investigati 6   Could not determine	28a. Date of Inji (Month, De on be d 28e. Place of Inj building, el	ury - At home c. (Specify) of my knowled	Bb. Time of Injury e, farm, stree	M 28 M et, factory,	other.  c. Injury a Work? 1 □ Ye office	4 ☐ Nursing H at as 2 ☐ No	autop perfo 1 Yes  th (Check only come 5 Residue) 28d. Describe I  28f. Location (Scity or Toy)	rmed? 2   1   1   1   1   1   1   1   1   1	death? 1 □ Yes  6 Wher (Specury occurred  and Number or Ru  e)	completion of cause 2 □ No  2 □ No  cits #0.5 P I Ce I
nan ninous z	To Be Completed	examiner?  1 Yes 2  27. Manner of Dea  1 Matural  2 Accident  3 Suicide  4 Homicide	th 5   Pending investigati 6   Could not determine 1   Certifying I   2   Medical Ex	28a. Date of Inji (Month, Date) 28e. Place of inji building, el	ury - At home c. (Specify) of my knowled	Bb. Time of Injury e, farm, stree	M 28 M occurred a estigation,	other.  c. Injury a Work? 1 □ Ye office	4 ☐ Nursing H  at  at  as 2 ☐ No  a, date and place nion, death occur	autop perfo 1 □ Yes  th (Check only come 5 □ Resident of the composition of the composit	rmed? 2 (ane) dence now inju	death? 1 □ Yes  6 Wher (Specury occurred  and Number or Ru  e)	completion of cause  2 No  2 No  aral Route Number,  s stated.  to the cause(s)
iled in by trie funeral director, page < sriould be d	Certification: To Be Completed	examiner?  1 Yes 2  27. Manner of Dea  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	th 5   Pending investigati 6   Could not determine 1   Certifying I   2   Medical Ex	28a. Date of Inji (Month, De on be d 28e. Place of Inj building, el	ury - At home c. (Specify) of my knowled	Bb. Time of Injury e, farm, stree	M 28 M occurred a estigation,	Other  C. Injury a Work?  1 □ Ye  office  It the time in my opi	4 ☐ Nursing H  at  at  as 2 ☐ No  a, date and place nion, death occur	autop perfo 1 □ Yes  th (Check only come 5 □ Resident of the composition of the composit	rmed? 2 (ane) dence now inju	death? 1 □ Yes  6 Wher (Specury occurred  and Number or Ru e)  s) and manner as and place, and due	completion of cause  2 No  2 No  aral Route Number,  s stated.  to the cause(s)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

		State Registrar  1. Decedent's Name (First, Middle, Last	)	C	ertificate of I		2. Date of Death		3. Time of Death
Physicia	ın	Geraldine Elizabet					Month Septem	ber 2 2	2008 5:30P M
/Medic Examin	41	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of	Death
Xuiiiii	48	Berlin Nursing & R			Berlin		T	Worcest	
Funeral Director		5. Social Security Number 6. Se 161-16-8061	TM OFTE	ge (In yrs. last birthd 90 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 4,	Year)	Birthplace (State or Foreig Country) ennsylvania
<b>2</b> □		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. inside City Limits
faryla	ō		<u>,</u>	Berlin					1 ∐Yes 2 🛣N
the N 28a-1 notifi	Director	Maryland   Worceste:  10e. Street and Number		Dermi	10f. Zip Code		10	0g. Citizen of Wh	at Country?
h with	al D	9347 Seahawk Road	1		2183			USA	
deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hyglene. Important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🗹 Widowed 4 ☐ Divorced	1  Yes 2 X If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🖾 No	Specify:		Specify:	Black
72 ho natur ilical I	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	pation during most of work	kina	16b. Kind of Busi	
nd 2 shours affind within 72 hours affialth and Mental Hygiene. 27 is marked other than "natural", or raumatic event, the Medical Exami	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) l	acher's aid			of Educa:	hia Board tion
iled w Hygiel ther ti nt, th	S	17. Father's Name (First, Middle, Last)			adnor b are		ne (First, Middle, I		
d be f antal h ced of	o Be	William Turner					unkno	wn	
should nd Me mark mark	2	19a. Informant's Name/Relationship (7	Type. Print)	19b. M	lailing Address (Street	and Number or Ru	ıral Route Number	, City or Town, S	tate, Zip Code)
1 and 2: Health a em 27 is		Sandra Morris-Smith	/daughter	934	7 Seahawk	Road - B			
permit. Pages 1 a Department of Hes mportant; If Item any injury or othe		20a. Method of Disposition  1	-	20b. Place of D	isposition (Name of crematory or other pla	ce)	Date	20c. Location - C	ity or Town, State
Pages nent of I ant; If Ite ury or o		4 □ Donation 5 □ Other (Specify	)	New Be	thel UMC	Cem. 9/5/	2008	Berlin, N	
permit. Pag Department Important; I any injury o		21. Sig tur of Funeral Service Licer	seen (	11.			•		Salis., MD
6 8 2 5 8		Talrum,	uxa	rey	JOLLEY MI	EMORIAL	CHAPEL.	P.A. 2	1801 Approximate
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	line.	t enter the mode of dy	ing, such as cardia	or respiratory are	631,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ASCI	D					
Examiner			Due to (or as	s a consequence of)	-				
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated overther	b. Due to (or a	s a consequence of)	:				
executed in and ial-transit	Examiner	l liat illitiated events	C						
an an		resulting in death) Last	Due to (or a	s a consequence of	):				
ate be hysici fhe bu	lical	•	d						
ertifica ling pl	Mec	IF FEMALE:	23c. If yes, outcom	ne of pregnancy	-			23d Date	of delivery
or Attending Physician; The law requires that the death certificate be executed first death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 □ Yes ≥ □ No 9 □ Unknown	1☐Live birth	2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnant 5 ☐ Other (specify)	су		Mon	
that the od by the detached		Part II. Other significant conditions	contributing to death	but not resulting in t	he underlying cause g	iven in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
uires sign	d by						1 🗆 Y	′es 2□ No	3 ☐ Probably
w req	Completed						24a. Was		lere autopsy findings availa
The law	l duc						autop perfo 1∐ Yes	rmed?/ d	eath? □Yes 2□No
iclan; Th certificate ector, pag		25. Was case referred to medical				26. Place of De	ath (Check only o		
iding Physiclan: h. After this certifica funeral director, p	To Be	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ☐ ER/Outp		ther: Nursing			
l or Attending Physician; The law requires tarter death.  Director: After this certificate has been signed in by the funeral director, page 2 should be		27. Manner of Death  ☐ Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury 28b. Ti Day Year) Inj	ury W		28d. Describe h	now injury occurre	ed
endir sath. or: At	atic	2 ☐ Accident investigatio		(1 All) (		]Yes 2 □ No	206 Logation /6	Stroot and Number	er or Rural Route Number,
oy t de	Certification:	3 Suicide 6 Could not be determined	28e. Place of i building,	injury - At home, farr etc. <i>(Specify)</i>	n, street, factory, office	9	City or Tov		er or Hurar Houte Number,
in the		29a. Certifier Check only 2 Medical Exa	hysician: To the be miner: On the basis and manner	of examination and	death occurred at the /or investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
Hospital or 14 hours after Funeral Directely filled in the control of the control	<u>2</u>		and manner		1 00 11			29d. Date signed	(Month Day Year)
o the Hospital or ithin 24 hours after o the Funeral Dire	Medical					nse number	i	Zod. Date 7.g.	(MOIIII, Day, Tear)
To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	Medica	29b. Signature and title of certifier				3199.		09/00	1/2008

08-06721 Andrew Rotruck

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar				Certif	ficate of	Death	7			Reg	. No.	200		
Physicia	an/	Decedent's Name (Fig. 1)	rst, Middle,Las	t)								Date of Death Month	Оау	Year	3. Time of Death	
edical Exami	ner		And	drew M	ichae	1 Ro	truck				s	eptember	2, 2008	8	1524 hrs	
		4a. Facility Name (if not	-	e street and n	iumber)		- 4			ocation of D	Death			ounty of Death gany	1	N.
		20525 McMulle					100	Rawlin			la	D . (D) (			10.1.	_
Funeral		Social Security Numb			7. Age (Ir	n yrs. last	birthday)	Months Months	r 1 Year	If Under 2 Hours	Min		`	Foreig		
Director		235-37-8537	1	XM 2 F		18	Yrs.		Days	710070		June 2	4, 19	990 <sup>∞</sup>	ountry) WV	
		Usual Residence of Dec													10d. Inside City Lim	
w any		10a. State 10b.	. County		100	c. City, To	wn or Locati	on							1 Yes 2 X	
Aaryland 28a-f show 1 at ouce.	ō	WV	Jeffer:	son		Chai	rles T									NO
e Maryland or 28a-f sho Ted at ouce.	Director	10e. Street and Number	г		•			10f. Zip	Code			100	. Citizen	of What Cou	ntry?	
the 3a or otifie		385 Palom	ino Pla	ace				2	5414					USA		
h with	Funeral	11. Marital Status		12. Was De	ecedent Eve Forces?	er in U.S.				anic Origin' Mexican, Pi		y Yes or No- an, etc.)	14.	Race - Amer White, etc.	rican Indian, Black,	
or ite	딃	1 X Never Married		1 Yes	2 X	No						,				
s afte ral", niner	اھ	3 Widowed		If Yes, Give Your Dates:				Yes 2	7.		المحددة	dana		ecify: Wh of Business/	ite	
hour natu	eted	15. Decedent's Educar Elementary/Seconda			(1-4 or 5+)	tea) II	6a. Deceden during mo			OO NOT us			IOD. KIIIU	Of Business/	industry	
0036 within 72 iene. rer than '	ble	12	19 (0-12)	College	(1-4-01-5+)		Stude	n+	,				CO.	11ege		
5-003 iled withi Hygiene. d other th	dmo	17. Father's Name (Firs	t Middle Last	)			Stude	1116	118	3.Mother's I	Name (Fir	st, Middle, M				
21215-00 uld be filed wit Mental Hygien marked other: event, the M	Be C	Mark Alle									,	e Rana		,		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	일	19a. Informant's Name/	Relationship (7	ype, Print )			19b. Mailing	Address						or Town, State	e, Zip Code)	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygewith the "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	-	Sherry Rot			r	Î	385	Palo	mino	Place	o - (	harle	s Tou	wn WV	25414	
e, n l and Healtl item		20a. Method of Disposit	tion				ce of Dispos	ition (Nan	ne of ceme	etery,	Di	ate	20c. Loc	ation - City or	r Town, State	
Baltimore, MD 2121 Departit: Page 1 and 3 should be fi Department of St aland and Mould be fi Important: If tiem 27 is market injury or other traumatic eyent.		1 X Burial 2 (			from State		matory or oth sant_V			Gdns	9/6	/na	Mar	tinshu	rg, WV	
Ltin artme ortan	1	4 Donation 5 21. Signature of Funera				i ica.								r & No		
Balt permit, Depart Impor	6 39	777 /	1 1			M0.70	F.,	nana	1 Uor	no - I	Lack	res-sp	encei	1. Ø NO	125	
Physician		23a. Part I. Enter the di	sease, or comp	olications that	caused the	death. D	o not enter th	he mode o	of dying, s	uch as card	diac or re	spiratory arres	st, shock,	or heart	Approximate Inter	
/Medical	1	failure. List only o		ach line. Multiple Ir	niuries										Between Onset a Death	and
xaminer		or condition resulting in		Due to (or as		ence of):										
		Sequentially list conditi														
	ine	if any, leading to immed cause. Enter Underlyin		Due to (or as	a consequ	ence of):										
	Examiner	(Disease or injury that i events resulting in deal		Due to (or as	a consequ	ence of):							-		1	
760, Ticate be executed physician and the burial - transit			d.													
760, ficate be exe g physician a	/Medical	UNPENDED		AMENDED	)											
760, ficate be g physic the bur	/We	IF FEMALE: 23b. Was decedent preg	nnant in the		s, outcome	of pregna	ncy			Je				Date of delive	,	
68 certif nding	ian	past 12 months?	yridire iir aro	1 Live	e birth gnant at tim	e of death				Ectopic p	regnancy		Mc	onth	Day Year	
Box 68 e death certificate attending ed for use as	Physician	1 Yes 2 No 9	Unknow		nown		5 Ot	her (Spec	Juy)				1			
O. Box 687 at the death certific d by the attending parached for use as t		Part II. Other significa	nt conditions	contributing	to death bu	ut not resu	ulting in the u	underlying	cause giv	ven in Part	l.	23e. Did tob	acco use	contribute to	o the cause of death?	?
, P.O ires that t signed by	d by										_ \	1 Yes	2 🗸 N	lo 3 Pro	obably 4 Unknow	wn
ords, w requir s been s should	ete											24a. Was a			autopsy findings availa	
Records, The law require	Completed	ù <del></del>			<del></del>						_	autops	ned?	death?		
ital Recionant The secretificate rector, page		OF Miss area referred to							ne Diago e	of Dooth /C	hook only	1 Yes 2	∐ No	1 🗸 Y	res 2 No	
ital iician s cert	æ	25. Was case referred texaminer?	_,	Hospital:	Inpatient	2 =	R/Outpatient			of Death (C	Nursing H		Residence	e 6 🗸 Othe	er: Scene	—
Physer thi	70	1 ✓ Yes 2 27. Manner of Death	No	28a. Da	te of Injury		8b. Time of I			at Work?		d. Describe h				—
Division of Vital Isla or Attending Physician: Is after death.  al Director: After this certiled in by the funeral director	Certification:	1 Natural 5	Pending	Sep 2	th Day Year	) 1	1510 hrs			es 2 🗸 N	. İDri	iver auto a				
ivision or Attendafter death Director:	icat	2 🗹 Accident	Investigati	28e Pl:	ace of Injury	/ - At hom	e, farm, stree	et. factory	office bu	ilding, etc.	28	f. Location (S	treet and	Number or F	Rural Route Number, (	City
Divi	i i	3 Suicide 6	Could not determine	be			/ Highway		,	5.	205	or Town, St 525 McMulle	ate) en Highv	way, Rawlin	gs, MD	
file on		2: 0 20	rtifying Physic						time, date	e and place						
To the How within 24 h To the Fur completely	Medical	one) 2 V Med	dical Examine	r:On the basi	s of examin	ation and	or investigat	tion, in my	opinion,	death occu	rred at th	e time, date a	nd place.	, and due to t	the cause(s)	
F S S S S S S S S S S S S S S S S S S S	Me	29b. Signature and title	of certifier	and manner	stateu.			290	. License	number			29d. Dat	te signed (M	onth, Day, Year)	-
7		Down.	u Div	LIMB					O.C.N	1.E.			Septe	mber 3, 2	800	
(9)		30. Name and address	of person who	completed ca	use of deat	th (Item 2	3a)									
		Donna M. Vinc	enti, MD	Assistant	Medical	Exami	ner 111	Penn:	Street, I	Baltimor	e, MD	21201				
	tate	31. Date filed (Month, D			Registrar's	Signature	Span	1.)								
Regis	trar	SEP	0 3 200	JO M	ALLE !	J.	ST. ST.									

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ORIGINAL

			1- State of Maryland / State of Maryland /		tment of Heal			iene <sub>9. No</sub> 2 0 0 8	30066
	Physici		1. Decedent's Name (First, Middle, Last)  Bradley Roache		-		2. Date of Death Month August	Day 200	3. Time of Death  1:33p M
1	/Medio Examin		4a. Facility Name (If not institution, give street and number) 15009 Jerimiah Lane		4b. City, Town, or Loca Bowie	ation of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last but 1 ☑ M 2 ☐ F 52  Usual Residence of Decedent			Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 1-22-19	year) 9. Bi	rthplace (State or Foreign Country)
	ith the Maryland or 28a-f show se notified at	Director	10a. State 10b. County 10c. City, To  MD Prince Georges Bowie  10e. Street and Number 15009 Jerimiah Lane		10f. Zip Code		10	Dg. Citizen of What C USA	10d. Inside City Limits 1 ☑ Yes 2 ☐ No country?
1215-0036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	ed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 [	as Decedent of Hispan Yes, specify Cuban, Me Yes 2 No Sp	ecify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: B	nerican Indian, te, etc. 1ack
Z	led within Hygiene. her than " nt, the Ma	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give ki life. DC	nd of work done during O NOT use retired) er Software	e Engin	eer G		f. Soulutions
Maryland	2 should be fi n and Mental H is marked of reumatic ever	To Be	William T. Roache  19a. Informant's Name/Relationship (Type. Print)		Address (Street and N	lphelia Number or Rura	J. Smit	h City or Town, State,	
Baltimore, M	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumatic en one.		11 I Burial 2 M Cremation 31 I Bernoval from State 1	of Dispositery, crema		ory 9–	15–2008 R	20c. Location - City of tiverdale, Manes Funer	r Town, State
7.	Physician /Medical Examiner		23a Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A metastatic Color Due to (or as a consequence)	on Ca					Approximate Interval Between Onset and Death 3 Months
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence				- u.v.		
O. BOX 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death	ath 3 🗆 I	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
cords, P.	quires that en signed b uld be deta	by P	Part II. Other significant conditions contributing to death but not resulting	in the und	lerlying cause given in	Part I.	23e. Did tob	XX	to the cause of death?  Probably 4 Unknown
я жесс	: The law re icate has be , page 2 sho	Completed					24a. Was ar autops perforn 1 □ Yes 2	y prior to	autopsy findings available o completion of cause of } es 2 □No
on or vital	ulng Physician: The	ion: To Be	XX Natural 5 ☐ Pending (Month, Day, Year)	Outpatient b. Time of Injury	Othor	☐ Nursing Ho		e) ence 6	pecify)
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification: T	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stree		1	28f. Location (St City or Town	reet and Number or I I, State)	Rural Route Number,
	the Hospi nin 24 hour the Funer ppletely fill	edical	29a. Certifier (Check only one)  1		estigation, in my opinion	n, death occurr	ed at the time, d	ate and place, and d	ue to the cause(s)
	To with	Σ	29b. Signature and title of certifier		29c. License nun D006661			9d. Date signed (Mod $0.0310$	S Year)
2	(10)		30. Name and address of person who completed cause of death (Item 23a Shalini Dogra, M.D., 1400 Forest G	Glen H		Silver :	Spring,	Maryland	20910
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 5 2008 32. Registrar's Signarie	D					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 30067 2008 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 31, 2008 1313 hrs ASHLEE MARIE Medical Examiner RUSSELL c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince Georges Hospital Center Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Hours Months Davs Director 217-25-7529 Country) Nov.1,1989 M 2 X F 18 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City. Town or Location Yes 2 XNo 28a-f show MD Montgomery Gaithersburg Directo 10g. Citizen of What Country? s 23a or 28a-f e notified at o 10e. Street and Number 10f. Zip Code 18405 Cherry Laurel Lane U.S.A. the 20879 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11 Mantal Status 12. Was Decedent Ever in U.S. items must be Armed Forces? White etc. 1 X Never Married 2 Married 2 X No Yes ò Black Specify: Yes 2 X No specify: Widowed Divorced If Yes, Give Year 72 hours after other traumatic event, the Medical Examiner more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", à 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed 10th None 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David D. Russell Ava M. Burleson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 19a. Informant's Name/Relationship (Type, Print) Ava M. Burleson (Mother) 18405 Cherry Laurel Ln, Gaithersburg, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Nat'l Mem. Pk 9/5/08 MD Laurel, MD Important: Ponation 5 Other Spec 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ture of Funeral Service 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications that caused the death **Physician** failure. List only one cause on each line /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last andtransit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED tending physician use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) has been signed by the att 2 should be detached for 1 Yes 2 No 9 🗸 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 0.0 ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? certificate h 1 🗸 Yes No Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? lospital: Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Other this ٩ 1 V Yes No funeral 28a. Date of Injury (Month, Day Year) Aug 31, 2008 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: Subject shot within 24 hours after death.

To the Funeral Director: All completely filled in by the fun 1246 hrs Division 1 Natural Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 160 46th Street, NE, Washington, DC determined (Specify) Alley 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertific September 1, 2008 O.C.M.E. tho completed cause of death (Item 23a) OCME Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. 31. Date filed (Month Pay Year) rar's Signature State 200 Registra

Ashler M. Russell

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Month **Physician** SEPT. 1000 M Gerald Rend1e /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico PENINGULA DEGIONAL MEDICALCENTER If Under 1 Year 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months 1⊠ M 2□ F 79 5-4-1929 England 219-28-1188 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location show 10a State 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, he Province Examination to a collined at 1 ☐ Yes 2X No Director Pittsville MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 5555 Ben Davis Road 21850 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1950-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: ģ 3 Widowed 4 Divorced 1953 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within ene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Department of Health and Mental Hygien.
Important: If item 27 Is marked other the any injury or other traumatic event, If a one. 5 Assemblyman Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Rendle 01ive Sussex William Janet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hazel Rendle - Wife 5555 Ben Davis Road, Pittsville, Maryland 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 9-4-2008 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Euneral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) ☐Yes 2☐No P.O. ed by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9/3/08 1)39204 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) CARROCC Steet SAlisbury md 21801 Yu 31. Date filed (Month, Day, Year) State 2008 SEP 05 Registrar

			For State Registrar	State of Ma	rylan	-	artment <i>tificate</i>					gien Reg. No	21H   8	3	30069	
	Physici	1. Decedent's Name (First, Middle, Last)								2. Date of Death  Month Day Yea					Time of Death	
	/Medic		4- 19-19-19-19-19-19-19-19-19-19-19-19-19-1						Location	of Death	Deptember 3, 200			-		
	) Lxamii		Doctors Community	Community Hospital								F	eorg	ge's		
	Funeral		5. Social Security Number 6. S	ex 7. Age		ast birthday) Yrs.	If Under	1 Year_ Days	If Under Hours	Min.	3. Date of Bir (Month, Da	ıy, Year	)   0	o <i>untry)</i>	(State or Foreign	
	Director		577-05-4744 'Usual Residence of Decedent		91						11/26/	191	6 Mai	ry1a	nd	
	ryland	_	10a. State 10b. County		10c. City	, Town or Loc	cation								nside City Limits	
	ne Ma :8a-f s	ecto		George's	Rive	erdale				_					IXIYes 2 □ No	
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 6126 54th Avenue				10f. Zip (						itizen of What Co .ted Sta			
	death ms 23	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	S. 13. V			ispanic Ori	igin? (Spec	ify Yes or No		14. Race - Am	erican Ir	ndian,	
36	it e	y Fui	1 Never Married 2 Married	0	ver in U.S.  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2 ☒ No Specify:							e, etc.	_			
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22	led wii lygien her th		12			Upho	lstere	er /		Lsher	(F <sup>2</sup> ) - A A A A - I - II - I		niture			
Shipley, Andrew Baltimore, Maryland 21215-0036	d be fill ental F ced oth	Be C	17. Father's Name (First, Middle, Last, Wilber L. Shiple)								First, Middle Cginia					
Z Z	should and Me mark umark	ဥ	19a. Informant's Name/Relationship (			19b. Mailin	ng Address	(Street a					or Town, State,	Zip Coa		
׎	and 2 ealth a 127 is		Emma Callaghan /	sister		9264	Cherr	y L	ane,	#48 <b>,</b>	Laure	L, M	D 20708			
Shipley Baltimore, N	jes 1 a t of He if Item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	lace of Disposemetery, cren	sition (Nam natory or oth	e of her plac	e)	Da	te	20c. l	ocation - City or	Town,	State	
7, T	it. Pag rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specif	y)	For	t Line				9/8/	2008		entwood			
	permi Depar Impor any Ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Aven Gasch's Funeral Home, P.A. Hyattsville, MD 207													
			23a. Part 1. Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between													
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Coronary Artery Disease 15										Ons	set and Death Vears		
	/Medical Examiner		Due to (or as a consequence of):										20			
		ē.	Sequentially list conditions D									20	years			
	cuted nd ransit	Examine	triat initiated events	min								20	years			
8760,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a		,	th							10 years		
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Box (	h certi ending use a	M/u	IF FEMALE: 23b. Was decedent pregnant	b. Was decedent pregnant 23c. If yes, outcome of pregnancy									23d. Date of delivery			
O e pt pt pt pt pt pt pt pt pt pt pt pt pt									у				Month Day Year			
								ı.	23e. Did tobacco use contribute to the cause of							
								1 🗆	1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown							
ecc	24a. Was an autopsy performed?    The state   The stat								24b. Were a	e autopsy findings available to completion of cause of						
25. Was case referred to medical examiner?  1   Yes   2   Invo								? es 2 □ No								
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sior	Attending r death. ector: After by the fune	catio	1	n	, rear)		М		Yes 2	No						
Divi	lor Att after d Direct	ertifi	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At ho . (Specif)	me, farm, stre	eet, factory,	office		28	3f. Location ( City or To	Street a wn, Sta	and Number or F te)	Rural Ro	ute Number,	
	Hospital 24 hours a Funeral I etely filled	Medical C	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best on miner: On the basis of and manner sta	examina	wiedge, death tion and/or in	h occurred a vestigation,	at the tir in my o	me, date a ppinion, dea	nd place, a ath occurre	nd due to the	cause date a	(s) and manner and du	as stated	d. cause(s)	
and manner stated.  29b. Signature and title of certifier  29c. Licen													9d. Date signed (Month, Day, Year)			
DS0913							3		09/03/08							
a N	(6)		30. Name and address of person who		eath (Item	23a) (Type,					6 1. 1 A.	1.	C-2 1-11	A2 F	), 20770	
	Sta	ate	31. Date fled (Month, Day, Year)	rester, MD 32. Registra	ir's Signal	ture	nover	101	KLUA	y, sa	TR JU	7 61	eenbelt	yn i	1. 20770	
	Regist		SEP 0 5 2008	bean &	1	mel										

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			For State Registrar	State of Ma	ai yiai iu /		tificate of			eg. No. 2	08	30070			
	Physici	an	1. Decedent's Name (First, Middle, Last		ngle				2. Date of Deat Month	th Day	Year	3. Time of Death			
	/Medic		Betty Loui	August	28	2008	0449 M								
	Examin	er	4a. Facility Name (If not institution, give					r Location of Deat	h		4c. County of Death  Talbet				
-	Francis		5. Social Security Number 6. Se		e (In yrs. last b	irthday)	Euste If Under 1 Year	If Under 24 Hrs	8. Date of Birth			lace (State or Foreign			
	Funeral Director			M 2 7		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) 07-22-	Year) -1932	yland				
	yland now		10a. State 10b. County		10c. City, Tov	vn or Loca	ation				1	0d. Inside City Limits			
	e Mar	Director	Md. Talbo	ot	Eas	ston						1 □ Yes 2 No			
	or 28	Dire	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Coun	try?			
	ath w	rai	9538 Black Do				L	601		USA					
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm "dical Event har must be not filled at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:	No If Yes, specify Cuban, Mexic			dispanic Origin? (San, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	Bla	14. Race - American Indian Black, White, etc.  Specify:  Black				
5-0	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workl						rkina	16b. Kind of Business/Industry					
2	within i	Completed	Elementary/Secondary (0-12)	College (1-4or 5	·+)	life. D	O NOT use retire	d) -	ing .	Allen	Allen Foods				
	filed w Hygie other t		17. Father's Name (First, Middle, Last)	ine	Worke		ne (First, Middle, i								
Maryland	d be f ental I ced of	o Be	John Potter	•				Agnus	Sulliv		,,,,				
ary	should and Men s marke umatic	오	19a. Informant's Name/Relationship (7)	pe. Print)	19	b. Mailing	Address (Street	and Number or R	ural Route Numbe	r, City or Town	, State, Zip	Code) 1 C O 1			
	and 2 ealth a n 27 is	١,	William Single	/ Husba	nd	953	Black	Dog A	ley,Apt	c.c 1,	East	on,Md.			
ore	es 1 a of He filtern		20a. Method of Disposition 1	Company Chair	20b. Place cemet	of Dispos ery, crema	ition (Name of atory or other pla	ce)	Date	20c. Location	- City or To	wn, State			
<u>E</u>	Pages ment of ant: If its lury or o		4 □ Donation 5 □ Other (Specify)		Md.	Vet	erans C	cem. 09-	-05-08	Hurlo	ck,M	aryland_			
Baltimore,	permit. Pages 1 a Department of Her Important: If Item any injury or othe		4 Donation 5 Other (Specify)  Md. Veterans Cem. 09-05-08 Hurlock, Marvland  21. Signature of Fundal Service Licensee  22. Name and Address of Facility  Bennie Smith Funeral Home  426 Dover St., Easton, Maryland 21601												
			23a. Part 1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused ne cause on each lin	the death. Do	not ente	r the mode of dyi	ng, such as cardia	c or respiratory arr	rest,		Approximate Interval Between			
1	Physician	er	Immediate Cause (Final disease or condition												
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):												
			if any, leading to immediate  Due to (or as a consequence of):								-				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Cons	e o to in	1 c	paint	Contina	2						
ó	exec an an														
68760,	rificate be executed ng physician and as the burial-transit	ical		em you	outly										
		Med	IF FEMALE:												
Вох	ires that the death cer signed by the attendir d be detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months?								23d. Date of delivery  Month Day Ye				
P.0	he de / the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5∐	Other (specify) _								
σ.	that t ned by detac	/ Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the und	derlying cause giv	en in Part I.	23e. Did to	3e. Did tobacco use contribute to the cause of death?					
Records,	quires in sign	d by	emphocad		1 🗷 Y	es 2□No	2 No 3 Probably 4 Unknown								
000	aw requir is been s 2 should	Completed		24a. Was a		24b. Were autopsy findings available									
SOUNCE SET OF PENALE:    23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 5   Other (specify)							med?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No							
/ita	clan: ertific	Be (													
£	hysio this c	P	1 Yes 2 No	lospital: 1 // Inpatie 28a. Date of Inju	ent 2 ER/C	Outpatient Time of	3 LI DOA		Home 5 ☐ Residence 6 ☐ Other (Specify)						
n C	ling F	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	ryat rk?	28d. Describe h	ow injury occu	ry occurred								
Division of Vital	l or Attending after death. Director: After I in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number,					
<u> </u>	i gitt	Certification:								n, State)		,			
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam		f examination a										
	To th¢ within Го the зощрі	Me	29b. Signature and title of certifier				29c. Licens		1	29d. Date sign					
Ddn597(2								2	8/2	28/0	18				
	Ths		30. Name and address of person who co	ompleted cause of d	eath (Item 23a	) (Type, P	rint)	- 1			DAC	-1			
	3		Horder S	ollet,	m)	0		Coste	on, m	0	116	101			
	Sta		31. Date filed (Month, Day, Year)  AUG 2 9 20		ar's Signature	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day | Month **Physician** 5,55 2006 ntemper <u>Curtis Garvin STEVENS</u> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Hagerstown 11 W. Baltimore Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 M 2 □ F West Virginia 63 Nov. 11 1944 Director 219-44-3047 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County rai", or Items 23a or 28a-f sho 1**▼**Yes 2□No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Funeral 11 W. Baltimore Street USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify. Specify: White ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Machinist Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James L. Stevens Mellie Bryant ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 W. Baltimore Street, Hagerstown, Md. 21740 <u> Vickie Stevens - Wife</u> Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park : 9/11/08 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home tred L. Vestas 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SMC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b I director, page 2 st autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🔀 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After the 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred → Natural 5 Pending investigation 1 □Yes 2 □ No ours after death neral Director: / filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Sextifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

6

State Registrar

DHMH 17 Rev 1/2001

and address of person who completed cause of death (Item 23a) (Type, Print)

200R

21740

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of M	laryland		artment ( <i>rtificate</i>			na Mer	, ,	JIENE leg. No.	0 0 0	Q	300	72	
- 6	Physici	an	Decedent's Name (First, Middle, Last)     Date of Death									th Day	Day Year 3. Time of Dea					
	/Medic		Christine B. Sprague  4a. Facility Name (If not institution, give street and number)					S					_			1:45	₽ <sup>M</sup>	
	Examin	er						4b. City, To						Prince (		ola		
-	Funeral		Kenaissan  5. Social Security N		- Riderwood Sex 7. A	ge (In yrs. la			Year	er Spr If Under 24	Hrs. 8.	Date of Birth	)				oreign	
	Director		579-09-	3230	1 ☐ M 2 🛣 F	89	Yrs.	Months D	ays	Hours		(Month, Day						
	and ww		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside C										Inside City L	_imits				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<b>Funeral Director</b>	Maryland Prince George's Silver Spring											1 □ Yes 2	<b>x</b> No			
	r 28a notit		10e. Street and Nu		-8-								10g. Cit	g. Citizen of What Country?				
	th wit 23a o Ist be		3	142 Gracefi	ie1d Road					20904	ŀ			1	U.S.A	•		
	r dea ems		11. Marital Status		12. Was Decedent Armed Forces	?	3. 13.	Was Deceder If Yes, specify	t of Hisp Cuban,	panic Origir , Mexican, f	n? (Specity Puerto Rica	Yes or No- an, etc.)		14. Race - Ar Black, W				
8 8 8	s afte	by Fu	1 ☐ Never Mari	1 Tes 2 If Yes, Give Year or Dates:	☐ Yes 2 ☑ No Yes, Give			1 ☐ Yes 2 No Specify:				Specify:						
1   25 -0036	hour tural	Completed b	3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education				16a. Decedent's Usual Occupation						16b. K	<b>Wh</b> ss/Indust	ite rv			
2 5 5	in 72  n "na Medic		(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			.5.)	(Give	e kind of work DO NOT use	done du	ring most o	of working							
212	d with giene er tha	ĕ	12					Hor	nemak	cer				Own	n Hom	e		
	al Hy I othe	Be	17. Father's Name	(First, Middle, Las	t)				1	18. Mother's	s Name (Fi	irst, Middle,	Maiden	aiden Surname)				
45pm arvland	Ment Ment arkec	To E	Arthur Ball									Annie I		unt				
Nar H	12 sh hand rism traum			ame/Relationship				ing Address (S										
	1 and Health em 27		Micha 20a. Method of Dis	el Sprague	- Son	20b. Pla	ace of Disp	Hickory osition (Name	of	- ;	Date			ocation - City				
イのひ altimore.	ages int of y or o		1 🖾 Burial 2	☐Cremation 3	Removal from State	e ce	emetery, cre	ematory or other	er place)	i								
107 altimor	artme		4 Donation 5 Other (Specify)  Parklawn Memorial Park 09/06/2008 Rockville, Maryland  21. Signature of Funeral Service Licerise  22. Name and Address of Facility									anu						
918 Ba	Dep mp any		Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904												904			
	No ven		23a. Fart1. Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or reart failure. List only one cause on each line.  Approximate Interval Between															
2	Physician		Immediate Cause (Final disease or condition Cerebrovascular Accident Week											ath				
	/Medical	Examiner	Due to (or as a consequence of):															
7	Examiner		Sequentially list co	onditions,	U	l Fibri		n										
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0	execur and al-tran	xan	that initiated event resulting in death)	s Last	c Due to (or a	ıs a consequ	ence of):								-			
DDB 68760.	ificate be executed g physician and as the burial-transit			•														
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<u>۱٬٬٬</u> ۾	that the death certifed by the attending detached for use a	Completed by Physician/M	IF FEMALE: 23b. Was deceder		23c. If yes, outcom	ne pf preg⊓ar 2 □ Fetal		□Ectopic preg	inancv					23d. Date of		٧		
2 C m m	e dea the att		in the past 12 months?  1 \( \text{Yes} \) 2 \( \text{ZNO} \)  9 \( \text{Unknown} \)  9 \( \text{Unknown} \)									Month Day Year  oo use contribute to the cause of death?			ar			
(b) a	hat the defact														phacco			
\$ \$	g an													2 No 3 Probably 4 ▼Unknown				
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Vital (		Be Co	25. Was case refe	rred to medical						26. Place o	of Death (C	1□ Yes Check only o		0 1 UY	/es 2[	No		
	S .s .f	To B																
> 5	ੂ ਜੂ ਹ		27. Manner of Dea	28b. Time	of 28c. Injury at 28d. Describe how													
- is	Attending r death. ector: After by the funer	catic	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No															
RIS 1.1		Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and City or Town, State								nd Number or Rural Route Number, e)							
Ξ"	olta urs ille		29a. Certifier	1 🔽 Certifying P	hvsician: To the bes	st of my know	wledge, dea	ath occurred at	the time	e. date and	I place, and	due to the	cause(s	s) and manne	r as state			
$\overrightarrow{}$	To the Hosp within 24 ho To the Fund completely f	edical	29a. Certiffer (Check only one) Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
_	To the within To the Comp	Me	29b. Signature and	29b. Signature and title of certifier 29c. License number								29d. Date signed (Month,				y, Year)		
				(F	XXX	₹.				D24035	5			Septembe	r 2,	2008		
	5				completed cause of				_		M - 7		01					
			Eugenio 31. Date filed (Mo		M.D., 3110	strar's Signat	ture			pring,	Maryla	and 209	U4					
	Regist	ate rar	200	SEP - 4	2008	all second	K,	Spark	,									

Division of Vital Records, P.O. Box 68760,

		State of Maryland / Dep		-	_	
	-	, roi	ertificate of Death		g. No. 2008	3 3 0 0 7 3
Physician		1. Decedent's Name (First, Middle, Last)  Madeline D. Smith		2. Date of Death Sept.	1 <sup>Day</sup> 2008 <sup>Year</sup>	3. Time of Death 4:04 AM
/Medica Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1 .
		702 Harrington Rd	Rockville		Montgome	PY nplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 177-07-1266 1 M 2 TF 94 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, NOV • 14	$\stackrel{\text{Year}}{,} 1913 \stackrel{\text{9. Birth}}{\stackrel{\text{Cou}}{\text{Cou}}}$	nplacë (State or Foreign Intry) Enn
and w	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
Maryl a-f sho	ğ	MD Montgomery Roo	ckville			1X Yes 2 □ No
vith the Mar	5	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	
s 23a	8	702 Harrington Road	20850	. 7. 1/	U.S.A.	
fter de	Laisia	1 ☐ Never Married 2 ☐ Married	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	, etc.
hours a	20.07	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ Mo Specify:	114		White
n "nat	completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)		6b. Kind of Business/li	naustry
ygiene er tha	5	Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs	Catalog Dept.		J,C.Penr	ny Store
2 should be filed within 72 hours after death with the Maryland is and Merital Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	200	17. Father's Name (First, Middle, Last)  Myron Cutchall		Gillet		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment and be notified at once.		1 11	ling Address <i>(Street and Number or Rui</i> 2 Harrington Rd			
ges 1 a it of He if item or othe		20a. Method of Disposition  20b. Place of Disposition  1 ☐ Bugal 2 反 Cremation 3 ☐ Removal from State	ematory or other place)		0c. Location - City or T	Fown, State
artmer srtant: ortant:		4□Portation 5□Other (Specify) Ardent	Crematory 9/4,		Hanover,	
permi Depar Impor any ir once.			22. Name and Address of Facility Snows 46 N. Washington			
		3a. Part 1. Ent if the scease, or complications that caused the death. Do not e shock, or leart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerof Due to (or as a consequence of):	cic Cardiovascu	lar Dis	ease	
Examiner		Coronary Art	erv Disease			
executed in and ial-transit		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying				
be executed ician and burial-transit	EYG	Cause (Disease or Injury that initiated events resulting in death) Last  C. Atrial Fibri Due to (or as a consequence of):	llation			
0 0 0	2	lacksquare d. Hypertension				
ding p	/ME	IF FEMALE: 23c. If yes, outcome of pregnancy			001 P ( )	
Hospital or Attending Physician: The law requires that the death certificat 24 hours after death.  Funeral Director: After this certificate has been signed by the attending phy itely filled in by the funeral director, page 2 should be detached for use as the control of the funeral director.	r II ysiciali/lileui	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	Day Year
res that t	۲ ک	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
w requires been sign should be	ed Dy			1 □ Ye	s 2 <b>√2</b> No 3 □ Pr	obably 4 🗆 Unknown
e law re has be ge 2 sho	nalaldillon			24a. Was an autopsy perform	prior to c	topsy findings available completion of cause of
certificate harector, page		25. Was case referred to medical	26 Place of Dec	1 ☐ Yes 2	X No 1 □ Yes	2 🗆 No
Physician: this certific	0 0	examiner? 1 ☐ Yes 2√ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Othor		nce 6 ☐ Other (Spec	cify)
ing Ph	5	27. Manner of Death 1 № Natural 5 Pending (Month, Day, Year) 28b. Time (njury (Month, Day, Year)	Work?	28d. Describe ho	w injury occurred	
death ctor: / y the f	Car	2 Accident investigation 3 Suicide 6 Could not be determined to the determined and the could not be determined.	M 1 Yes 2 No	28f. Location /Str	reet and Number or Ru	ural Route Number
tal or A	cer micanon. 10	4 Homicide determined building, etc. (Specify)	neod, radiory, office	City or Town	, State)	rai Floute Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the carred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
10	M	29b. Signature and title of certifier Gants MD	29c. License number D41102	25	9/2/08	h, Day, Year)
100		30. Name and address of person who completed cause of death (Item 23a) (Type			ND 0005	A
State		31 Date filed (Month Day Year) 32 Maistrar's Signature	ors Drive, Germ	antown,	MD 2087	4
State Registra	•	SEP - 4 2008 Seem &	book			
HMH 17 Pay 1/200	4					

			For State Registrar	State	of Marylan	•		nt of H te of L		nd Me	ental H		ne 20	08	30074
		107	Decedent's Name (First, Middle	e, Last)							2. Date of	Death	-		3. Time of Death
	Physicia		Stan1	ey Joser	oh Soya					S	Month		3, 20	Year 108	9:45 A. <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution				4b. City	, Town, or	Location of				4c. County		
		٠.	Casey House-M	ontgomery	Hospic	e		Rockv	ille				Mont	gome	rv
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Undo	er 1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of (Month,	Birth Day, Yea	Т		lace (State or Foreign
	Director		168-09-5102	1⊠ M 2□ F	88	3 Yrs.	Worters	Days	Trouis		Oct.				A
			Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation				_			1	0d. Inside City Limits
	sho	៦	,												1XX Yes 2 □ No
	28a-1	Director	Maryland Monts  10e. Street and Number	gomery	Ro	ckvill	_	ip Code				10a	Citizen of V	Vhat Cour	ntry?
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-	1s 23	Funeral	298 Lynch Stre		cedent Ever in U	S. 13.	Was Dec	20850 edent of H	ispanic Origi	in? (Spec	cifv Yes or		United 14. Rac		can Indian,
0	riten	Fur	1 ☐ Never Married 2K Marr	ied Armed F	forces? 2∏No 19	42-	If Yes, sp	ecity Cuba	in, Mexican,	Puerto F	Rican, etc.)		Blac	k, White,	etc.
200	al",o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	Dates: 19	46	1 □ Yes	2 <b>™</b> No	Specify:				Specify	Whi	te
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yland	be free within 72 hours aren dean with the maryland ntal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, I've hadical Examination is used to notified at	Be	17. Father's Name (First, Middle,	Last)					18. Mother's	's Name	(First, Mid	dle, Maio	len Surnam		
7 2	Men larke	မ	Jozef	Soya							Bron				mowska
Mar	is m		19a. Informant's Name/Relations			1		_ ` _	and Number				·		
ָב ב	Health Health Sm 27 Sm 27 Shert		Lillian Marie S	Soya/Wite					et, Ro		ille, ate		yland . Location -		
5	permit. Fages I and 2 should be filed within 7.2 hours after death with the Marylan permit. Fages I and 2 should be filed with Martial Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I in "Mutical Examine" is ust by inclined at since.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal from	n State	Place of Dispo cemetery, crei			i .					•	
Dallimor	rtmer rtant		4 □ Donation 5 □ Other (S		Par	klawn				6/20				-	Maryland
ם ח	mpo any l	1	21 Surature of Funeral Service	License	0.00				ss of Facility						m 20077
			23a. Part 1. Enter the disease, or	complications that	caused the deat								ersbu	rg, N	ID. 20877 Approximate
			shock, or heart failure. List			iii. Do not en	ter the m	ode or dyn	ig, sucii as c	ardiac of	riespilatoi	y arrost,			Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	r Cancer									$\rightarrow$	
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		er	Sequentially list conditions, if any leading to immediate		nary Art		Lseas	se							
1	ured Insit	Examiner	Cause (Disease or injury	Cere	brovasci	ılar Ad	ccide	nt							
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0/00,	physician and sthe burial-transit	dical		d											
0	ng ph as th	ledi													
Š	attending for use as	N/	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Tectonic	pregnanc					4	te of deliv	,
	ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (		, 			_	Mo	onth	Day Year
י נ	by the	Physician/Me	9 Unknown								1				
'n	w requires that the displaying the should be detached	b	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	ınderlying	cause giv	en in Part I.						he cause of death?
cords,	sen s	fed										∐ Yes ———	2   No	3 Pro	bably 4 🛛 Unknown
ני ני	as be	Completed									24a. V	utopsy		Were auto	opsy findings available ompletion of cause of
ב ו	cate has	Š									p	erformed s 2 <b>½</b>	!?	death? 1 🔲 Yes	
NI G	ertific ector,	Be (	25. Was case referred to medica examiner?						26. Place of	of Death	(Check or	ily one)			
5	n h After this certific funeral director,	.0	1 Yes 2 No		] Inpatient 2 □	, ,			4 🗀 Nur						fy) Hospice
	After	iio	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	g (Ma	e of Injury onth, Day, Year)	28b. Time o Injury		28c. Injur Worl	k?		28d. Descri	be how i	njury occur	red	
	tor: )	cat	2 Accident investi 3 Suicide 6 Could	not be			M		Yes 2□N		204 14				- L Down Atombo
	after death  Director: , d in by the f	Certification: T	4 ☐ Homicide determ	inod 200. Flat	ce of Injury - At h iding, etc. <i>(Speci</i>	ome, tarm, sti fy)	reet, facto	огу, опісе		2	City or	Town, S	tate)	oer or Hur	al Route Number,
۔ آ	ours a	ပ္	29a, Certifier 1X Certifyii	ng Physician; To t	he hest of my kn	nwledge deal	th occurr	ed at the ti	me date and	d place :	and due to	the caus	e(s) and m	anner as	stated
	to the hospital or Attending Fribstoan. The law requires that the beath certifiting 24 bounds after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical		Examiner: On the											
	Nithin North	Me	29b. Signature and title of certifie	r, 0			2	9c. Licens	e number			29d.	Date signe	d (Month,	Day, Year)
			D. 1000 €	rchou	, ms		-	DOC	637	142	8	Se	ptemh	er 3	, 2008
	12+1		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)					, , ,	1 1110		
			Jocelyne Touke		ou, M.D	., 201	East	t Uni	versit	ty Pa	arkwa	у, В	altim	ore,	MD. 21218
	Sta		31. Date filed (Month, Day, Year)	4 2008 32.	gistrar's Sign	ature	1000	6							

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 09:30A M 30, 2008 August William Stanley Stetson, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Kent 5456 Newt Downey Rd. Rock Hall Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 1⊠M 2□F 9/9/1930 PA 77 191-24-7866 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ▼No Rock Hall Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21661 5456 Newt Downey Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ★ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White WWII 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Post Master 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Kirsch Frank L. Stetson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5456 Newt Downey Rd. Rock Hall, MD 21661 Joyce H. Stetson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 9/2/2008 Stevensville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 Approximate Interval Between Onset and Death ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or shock, or heart failure. List LYEUrs ophaguel Rupture Requiring Esophagectony Lyeur

Physician /Medical Examiner

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural", or

I Hygiene.

Department of Health an Mental Hygie Important: If Item 27 Is arked other any injury or other traus at cevent, the

Pages 1 and 2 s ould be

the Medical

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

5

Completed

Be

dilation of exophages leading to repture

	Immediate Cause (Final disease or condition resulting in death)	
cal Examiner	Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injur that initiated events resulting in death) Last	liate III
Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	HIS?
d by P	Part II. Other significan	
mplete	Emphysen GERO, Re	fusal
o Be Co	25. Was case referred examiner?	to medical
fication: T	2 Accident	☐ Pending investiga
Cert	# [] Tiomicide	1

4⊟Pregnant at time of death 9⊟Unknown	5 Other (specify)
s contributing to death but not resulting in	the underlying cause given in Part I.
of Feeding Tube	, ,
J	26. Place

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

		ribute to the cau	
1 🗌 Yes	2) No	3 ☐ Probably	4 □Unknown

23d. Date of delivery

Year

Month

	~
4a. Was an autopsy performed? □ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1   Yes   2   No
1 1es 21 10	12100

25	. Was case referr	red to medical				26. Place of Dea	th (Check only one)	
	examiner? 1 ☐ Yes 2	<b>v</b> o	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 🗆 🗅	OOA Other: 4 Nursing H	lome Residence	6 ☐Other (Specify)
	. Manner of Death	n 5  □ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		home, farm, street, cify)	facto	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
20	2a Cortifier	Certifying Ph	vsician: To the best of my k	nowledge, death or	curre	ed at the time, date and place	e, and due to the cause	(s) and manner as stated.

3 Ectopic pregnancy

29a. Certifier (Check only one)	Certifying Physician: To the best of my knowledge, Dimedical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and due /or investigation, in my opinion, death occurred at th	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
20h Signature an	d title of certifier	29c, License number	29d. Date signed (Month, Day, Year)

s of person who completed cause of death (Item 23a) (Type, Print)

(Kiny Mil). 120 Spee Road Chapter Dwn, MD 2 162 2

Day, Year)

32. Reg Krar's Signature

State Registrar

Medical

within 24 hours after death.

To the Funeral Director: A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Items 23b, 25, 27, 28a-f per me, 2884, 10/17/08dhb

Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4:55 AM Mary 80 29-2008 Sarna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Coastal Wicomico Hospice at the Lake 8. Date of Birth (Month, Day, Mar. 22, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F Michigan 87 1921 363-12-1976 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland | Somerset Westover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 21871 25724 Drum Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Healthcare Surgical Scheduler 12 none 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evants. Rose Pleciak John Pleciak 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25722 Drum point Road, Westover, Md. 21871 Rosemarie Bryant 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Salisbury Crematory 08/29/2008 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ignature of Funeral Service 22. Name and Address of Facility Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hinman Funeral Home, Princess Anne, Md. 21853 Immediate Cause (Final Res Physician pirat resulting in death) /Medical Due to (or as a consequer ce / f): Examiner Thermal injuries and Smoke Inhalation with Complications if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 ☐ Other (specify) ed by the a detached f 0 s been signed by t should be detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Record 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes No page certificate 1☐ Yes Division or Vital Hospital or Attending Physician: 44 hours after death. Funeral Director; After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 08/10/08<sup>ay</sup> Year) 3:50a.m. Subject in mobile fire. 1 ☐ Yes 2 No Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Bural Route Number City or Town, State) 25724 Drum Point Road, Westover, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Mobile Home within 24 hours at Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 🖊 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of deat of Item 23a) (Type, Print) 31. Date filed (Month State 2008 Registrar

DHMH 17 Rev 1/2001

		Please Type or Print in Blac State of Maryland /				-	_	Э.
	_1	For State Registrar		rtificate of De			g. No. 20	08 30077
Physician /Medical	4	1. Decedent's Name (First, Middle, Last)  GREGORY  SCUTT				2. Date of Death Month	Pay C	3. Time of Death
Examiner		4a. Facility Name (If not institution, give street and number)  Mandrin Chesapeake Hospice House		4b. City, Town, or Loc Harwood	ation of Death		4c. County of I	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year   If U	ours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
Director	h-	Usual Residence of Decedent				May 21,	1946 V	irginia
Marylar -f show fled at		10a. State VA 10b. County 10c. City, To		cksburg				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ifter death with the Mar r items 23a or 28a-f sh iner must be notified		10e. Street and Number 638 Pelham Street		10f. Zip Code 22401		10	g. Citizen of Wha	at Country?
ar, o	2	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☒ Yes 2 □ Xer  1 ☒ Yes 3 □ Wietnam  Year or Dates: War	13.	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🏋 No Sp		cify Yes or No- lican, etc.)		American Indian, White, etc. White
ed within 72 houygiene.  Per than "naturality the Medical E.	Donaldino	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Gollege (1-4or 5+)	(Give life. I	dent's Usual Occupation kind of work done durin DO NOT use retired) urance Agen	ng most of workin	g	6b. Kind of Busin	,
ould be filed Mental Hyg arked other attic event, f	3	17. Father's Name (First, Middle, Last) Winfield F. Scott, Sr.		Ma	Mother's Name	Turphy		
and 2 sh ealth and n 27 is m				ng Address (Street and I Pelham Stree				
Pages 1 aunent of Heannt: If Item		20a. Method of Disposition 20b. Place	of Dispo	osition (Name of matory or other place) Crematory, LLC	Sept.	nate 02	Oc. Location - Cit	
permit. Departr Imports any Inji		21. Signature of Fugeral Service Licensee	2 <u>′</u>	Name and Address of Barranco & 195 Gov. Ri	Sons, P.	A. Seve	rna Park rna Park	Funeral Home , MD 21146
Physician /Medical Examiner		resulting in death)  Due to (or as a consequence)	not ent	ter the mode of dying, su				Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Divisional Machinal Examination		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence consequence consequence)  Due to (or as a consequence consequence)	,					
w requires that the death certificate be been signed by the attending physicis should be detached for use as the buttered by Dhysician Medical	I yalcıdı vivic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of Month	
equires that en signed b	2	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause given in	n Part I.	23e. Did tob	A	ute to the cause of death?  ☐ Probably 4 ☐ Unknown
icate has been so page 2 should						24a. Was ar autops perform 1∐ Yes 2	y prid ned? dea	re autopsy findings available or to completion of cause of ath? ]Yes 2 □ No
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	2	1 Matural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Outpatier o. Time o Injury	of Other: Other: 28c. Injury at Work?	S. Place of Death  4 Nursing Hon  2  2 No	ne 5 Reside	//	(Specify) HOSPICE
To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Macdinal Cartification:		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)				City or Town	, State)	or Rural Route Number,
thin 24 hour the Fune ompletely file	ובחוכשו	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, deat and/or ir	vestigation, in my opini	on, death occurre	ed at the time, d	ate and place, an	d due to the cause(s)
X/00 )	-	29b. Signature and title of certifier		29c. License nu	7443	8	ed. Date signed (	29, 2008
160x		30. Name and address of person who conhideted cause of death (Item 23a St. 1) Late filed (Month, Day, Year) 32. Segistrar's Signature	45	DEFENSE	Han	way Ar	vn APOLS	m 021401
State Registra		31. Date filed (Month, Day, Year) SEP 0 3 2008 32. egistrar's Signature	19	back				
HMH 17 Rev 1/200	1		7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 2:25 PM 09 02 2008 Elizabeth Yvonne Simpson /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner CAMICO The Lake lisba Hospiceat If Under 1 Year | If Under 24 H/s Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Min 1 □ M 2 🖾 F 213-70-7905 49 Oct. 1958 Georgia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examiner must be notified at 1 □Yes 2 X No Director Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 21801 USA 1501 Duchess Drive Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 21 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. à 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Head Start nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental em 27 is marked o Waltine Wiggins Brodis Shuman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4739 S. Upper Ferry Road - Eden, MD 21822 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra Willie Walker, Sr./brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 5, 2008 Salisbury, Maryland Salisbury Crematory 22. Name and Address of Facility 1213 Jersey Road - Salis., MD 21. Şigra ure of Funeral Service Licenses 21801 W JOLLEY MEMORIAL CHAPEL, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATTO COLON **Physician** CARCINOUNA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>S</u> 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ∐ Yes 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No #☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058410

State Registrar

31. Date filed (Month, Day, Year)
SEP 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

P.O Box 1733 SACIS DUNY cuy 21802

State of Maryland / Department of Health and Mental Hygiene [ ] [ ] [ ]

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Bryan Scott Smith 0830 M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA EEGIONALMENCAL CENTER SALIST wicomic If Under 1 Year 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Hours Months Days 212-70-8061 Maryland 4/6/1958 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "motical Examinating and the motified at 1 ☐ Yes 2 XNo Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatte event, the Medical Examiner is neat be in 27674 Crooked Oak Lane 21801 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) plumber plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wayne H. Smith Sr. Mary Ann Fink 19a. Informant's Name/Relationship (Type. Print)
April Paranilam/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2020 Whistler Ave., Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/4/08 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22 North Address of Received Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to initial acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to (or as a consequence of) Examine the death certificate be executed and Due to (or as a consequence of) for use as the burial-P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manno of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed, (Month, Day, Year) 29b. Signature and title of certific oP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ignatius Dinardo 106 Milford St., Salisbury, MD 21804 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 04 2008 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State	State of	of Marylar		artment of F		nd Mental I	Hygier	000	0	20000
			Registrar  1. Decedent's Name (First, Midd.	1- 141		Cei	rtificate of	Death	0. Data of	Reg. N	10. <u>Z</u> U U	8	30080
	Physic	an	, ,	, ,					2. Date of Month		Day Ye		3. Time of Death
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-	Examili	iei	Southern Maryl		· ·		Clinto				Prince		rge's
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		4 Hrs. 8. Date of (Month)				ce (State or Foreign
	Director		421-58-1262	1 □ M 2 <b>X</b> F	62	Yrs.	Wioning Days	Tiodis			1946		bama
	land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					100	I. Inside City Limits
	Mary Frsh	ţ	MD Princ	e George'	6	Fort	Washingt	* Om					1⊠Yes 2□No
	h the	irec	10e. Street and Number	e ocorge	0	1011	10f. Zip Code	-011		10g. (	Citizen of Wha	t Country	y?
	23a	Funeral Director	2701 Lumar Dri	ve			20744				U.S.		
	tems	nue	11. Marital Status	Armed F			Was Decedent of H	lispanic Origi an, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - A Black, W		
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Everginer cust be notified at	y F	1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	If Yes. G	2 X No ive		1 □Yes 2 <b>K</b> No	Specify:			Specify:	Blac	k
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Maryland	d Mer narke	은	Sidney Ward			T			zabeth Ur				
Mai	d2sh than t7 is n traun		19a. Informant's Name/Relations		- <b>h</b>		ng Address (Street					te, Zip C	Code)
e,	Heal tem 2		Cedric L. Jack 20a. Method of Disposition	cson / Nel			Fieldston sition (Name of matory or other place		Date		Location - City	or Tow	n. State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventions out two notified at once.		1⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State			i	/12/2000		,		
alţi	permit. F Departm Importar any Injur		21. Signature of Funeral Service		FC.	Line C	1n Cemet	ss of Facility	McGuire	Fune	Brentwo ral Se		
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1	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):			*				
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<u> </u>	Physician: r this certific ral director, I	면 면	examiner? 1 ☐ Yes 2 ☐ Ho	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Othe	or.	sing Home 5 🗆 R		6 ∏Other /	Specify)	
		Ë	27. Manner of Death 1 ☐ Natural 5 ☐ Pendir	28a. Date	of Injury oth, Day, Year)	28b. Time of Injury	28c. Injur	y at	-		jury occurred	,,	
Sio	ottendli death. ctor: A y the fu	catic	2 Accident Investi	gation		. ,		Yes 2 □ No	0				
Division	or Attending ifter death. Director: Afte in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	pined 28e. Place	e of Injury - At ho ling, etc. <i>(Specit</i>	ome, farm, stro fy)	eet, factory, office		28f. Locatio City or	n <i>(Str</i> eet To <i>wn, St</i> a	and Number o ate)	r Rural I	Route Number,
	pital		29a. Certifier 1 Certifyin	ng Physician: To the	a boot of my line	ladaa daad			- lane and due to	41	-/->		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical one)	Examiner: On the I	pasis of examination of the state of the sta	ation and/or in	vestigation, in my o	pinion, death	n occurred at the tir	ne, date a	and place, and	due to t	ne cause(s)
	Vithin Fo th	Se l	29b. Signature and title of certifie	1 1.			29c. License	e number		29d. [	Date signed (M	onth, Da	ay, Year)
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	10		30. Name and address of person	who completed cau	se of death (Item	n 23a) (Type,	Print)		Pater,		-0		
			9/35/10	is Cata	my Rc	Sw	Le 23	5 C	Palos,	10	2073	1_	
	Sta Registr		31. Date filed (Month Pay, Year)	2008	egistrar's Signa	iture	well						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 055 AN 2228 aine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 880 Doris Drive Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) 1**∑**M 2□ F 67 213-36-5820 **Director** 20,1940 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any onnee. Anne Arundel Arnold 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 USA 880 Doris Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No 1959—
If Yes, Give
Year or Dates: 1963 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ▼No ģ Specify: White 3 Widowed 4 Divorced 1963 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker General Motors 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William M. Tallent, Sr. Ernestine I. Reese ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Mary Tallent/ Wife 880 Doris Drive Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 02, Crownsville, MD 4 Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2008 22. Name and Address of Facility Barranco & Sons, 21. Signature of Foreral Service Licenses P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final eat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are ultimated to the continuous could be a sequent to the continuous Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performe certificate 2 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \subseteq Nursing Home \quad 5 \subseteq Residence \quad 6 \subseteq Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Best gale Rd Sute 300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0°3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:00a M 2008 Allan Vail August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Annapolitan Assisted Living Birthplace (State or Foreign Country)
 New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 22, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🔀 M 2 🗆 F Director 077–18–2062 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinational banding an once. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No MD Anne Arundel Arnold Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 753 Match Point Drive 21012 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give ₩WII Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna E. Clifford Reynold M. Vail ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 603 Pasture Brook Road Severn, MD 21144 Michael A. Vail/ Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Atlantic Crematory of other place)
LLC Sept. 02, 1 ☐ Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 2008 5 ☐ Other [Specify] Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Par Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease r condition resulting in death) EIMERS Physician MONDUI /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Decays of that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ▲ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specific 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Division of Vital Records, P.O. Box 68760, 24 hours after deatl Funeral Director: within 2 the 0

State Registrar (Check only one)

29b. Signature and title of certifier

and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

race NA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registrary Amend#20b. 20c. PerFHPCC9-5-08cm Certificate of Death Reg. No. 1. Decedent's Name (First, M 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:12 P M ashana N. W. Lon 8 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Min. 1 □ M 2√2 F Months 08/07/1984 New Jersey 146-78-8306 24 Director Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinar must be positived at 1 Yes 2 □ No Director N.J. Atlantic City Northfield 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 401 Jackson Avenue 08225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 ∑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □KNo Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Casino Cage Cashier B.A. Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shawn Wilson Bernice L. Campfield ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. Bernice L. Campfield - Mother 401 Jackson Avenue; Northfield, NJ 08225 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 200. Place of Disposition (Training of other place)
FOOT factor Curry Centerry
Placesont Ville Centerry
09/09/2008 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Flog Harbor, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Immediate Cause (Final **Physician** Injuries Multiple disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that in its later and the control of the c PROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). physician a the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical HERITE attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnatcy Day Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has autopsy perform certificate 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 ☐ Natural 5 Pending investigation ours after death.

neral Director: A

filled in by the fu death. 1 ☐ Yes 2 X No 8/30/08 155 AM ATV into 2 Accident a tree 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 14550 Bunks ODER Rd. Newburg M. Residential 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8/30/08 1912167495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St auren E. Rice Baltimore, MD

31. Date filed (Month, Day, Year) State Registrar

SEP 0 5 2008



ysicia		1. Decedent's Name (First, Middle, Last)  Dorothy Palma W	hitman						2. Date of De		2008	3. Time of Dea 8:35 p
Medic camin		4a. Facility Name (If not institution, give s							County of Dea			
Callilli	EI	6132 Summit Str				Lghm				Ta	albot	
neral ector		5. Social Security Number 6. Sex 220-28-1080	7. Age (In yrs 75	. last birthday) Yrs.		r 1 Year	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 11-1-	th ay, Year) -193	9. Bir C N	thplace (State or Fo ountry) Iew York
ㅋ		Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   Md   Talbot   Tilghman   10f. Zip Code										10d. Inside City L
pailing	Director											1 X Yes 2
ust be notified at	Dire	10e. Street and Number 6132 Summit Str	eet			2167	1			-	zen of What C USA	ountry?
the Madical Examiner TW	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Morrored	1 ☐ Yes 2 🛣 No If Yes, Give 1			Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc I □ Yes 2 No Specify:			ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi	
Asdical Ex	Completed t	3 Widowed 4 Doworced Year or Dates:  15. Decedent's Education (Specify only highest grade completed) (Give kind of work done durin (life. DO NOT use retired)					done during most of working				nd of Business	s/Industry
The A			College (1-4or 5+) Years	Ac	cour	ntan		er's Name	(First, Middle			busines
ntic ever	To Be	17. Father's Name (First, Middle, Last)  August Palma							Ganz	, Maiden	Sumame)	
other traumatic		19a. Informant's Name/Relationship (Type Richard Palma (	•		-						r Town, State, . 3563	
or othe		20a. Method of Disposition 1 🗆 Burial 2 🛣 Cremation 3 🗆 R	20b.	Place of Dispo cemetery, crei apitol	sition (Na	me of other place	9)		ate	20c. Lo	cation - City or	Town, State
eny injury or of once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License		-							•	PC 1.21663
ine purial-transit	Examiner	23a. Part. Enter the disease, or complishock, or heart faifure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	ath. Do not ent	er the mod	de of dying	g, such as	cardiac	or respiratory a	arrest,		Approximate Interval Betwee Onset and Dea
ימכווסט וטי עשפ עט ויום טעוומן.	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 5 No 9   Unknown		⊒Ectopic p ] Other (s <sub>i</sub>						23d. Date of de Month	3d. Date of delivery Month Day Year	
should be detac	Ď	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying	cause give	n in Part I					to the cause of deat
page 2	Completed										24b. Were a prior to death?	
director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 ☐ fnpatient 2 ☐	☐ ER/Outpatier	nt 3□ D	OA Othe	<b>ar</b>		n <i>(Check only</i> me 5 Mr Res		6 □Other (Sp	ecify)
funeral	ation; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. fnjury Work			28d. Describe			<b></b>
filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, factor	y, office				(Street an	1 4	Rur I Route Number
9	Medical		ician: To the best of my kr ner: On the basis of examin and manner stated.									
complet	Me	29b. Signatur, and title of conflict	wish; us D	) .		c. License		187			te signed (Mor	nth, Day, Year)
.												

DHMH 17 Rev 1/2001

			For			artment of H		ental Hyg	giene		
A	mended	it	State Registrar#9, perF. Hom		A WCHDCe	ertificate of L		2. Date of Dea	Reg. No.	108	3 0 0 8 5 3. Time of Death
П	Physici		Decedent's Name (First, Middle, Lase     Edward Watson	t)				Month 9	Dav	008	9:00 A M
1	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death			nty of Death	3.00 N
7	Lxamiii		65 Newport Dr.			Berli	n		Wor	cester	•
	Funeral Director		203-20-8010		(In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 3/3/19	19 <sup>Year)</sup>	9. Birthp Court	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	Maryl -f sho fied a	tor	MD Worces	ter	Berl:	in					1 ☐ Yes 2X No
	h the or 28a	irec	10e, Street and Number			10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	23a c ust be	ralD	65 Newport Dr.			21811			USA		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent of Hi If Yes, specity Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	Spec	lace - Americ lack, White, cify: Whi	etc.
21215-0036	72 hou natura Ical E	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dec	edent's Usual Occupa	ation during most of working	ag I	16b. Kind of	Business/In	
218	ithin 7 ne. nan "r	nple	Elementary/Secondary (0-12)	College (1-4or 5-	+) 1	e kind of work done of DO NOT use retired		, y	Tolo	nhana	Company
121	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)		Equi	ipment Mai	ntenance 18. Mother's Name	(First Middle			Company
anc	d be fi	Be c	Edward D. Watso					dred Fr			
Maryland	2 should be fi and Mental H Is marked ot aumatic ever	유	19a. Informant's Name/Relationship (7		19b. Mai	ling Address (Street a				vn, State, Zip	Code)
	1 and 2 Health a tem 27 Is		Esther Watson / w	rife	65 1	lewport Dr	., Berlin	, MD 21	811		_
ore,	of He of He rem		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cr	oosition (Name of ematory or other place	e) D	ate	20c. Locatio	n - City or To	own, State
ij	Pag Iment Iant: I		4 □ Donation 5 □ Other (Specify	)		lopen Cre		2008			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		21. Signature of Fun Service Licen	3 luba	(	22. Name and Address 108 Willi		urbage erlin,			e 
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each in	the death. Do not e	nter the mode of dyin	g, such as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
q	Physician		Immediate Cause (Final disease or condition	a. Alzhei	mel's Pi	scase					Onset and Death
7	/Medical Examiner	П	resulting in death)	Due to (or as a	a consequence of):						
	X.	<u>.</u>	Sequentially list conditions,	b. — Due to (or as a	a consequence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Error brossy, if Cause (Disease or injury that initiated events		,						
ó	ficate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as a	a consequence of):						
8760,	ate be nysicia he bu	dical		d							
9	ertifica ling ph e as t	Med	IF FEMALE:	00-16							
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome   1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	<u>'</u>			Date of deliv Month	ery Day Year
	s that ned by deta		Part II. Other significant conditions of		t not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use c	ontribute to t	he cause of death?
ıdş	w requires that s been signed to should be deta	ed b	Dishetes Melli	W 1				1 🗆 '	Yes 2D No	3 □ Pro	bably 4 □Unknown
Vital Records,	slcian: The law re certificate has be irector, page 2 shc	Completed by						24a. Was autor perfo			opsy findings available ompletion of cause of
/ita	Physician: The this certificate har all director, page	Be C	25. Was case referred to medical examiner?			1	26. Place of Death				
7.	≥ .ഈ ⊅	은	1 Yes 2 No	Hospital: 1 ☐ Inpatie			4 Li Nursing Hor		dence 6 🗆		fy)
Division or	After After funera	ion:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	y 28b. Time Year) Injury	Wor	yat k? Yes 2 □ No	28d. Describe I	how injury occ	curred	
isio	l or Attend after death Director:	icat	3 Suicide 6 ☐ Could not be		ıry - At home, farm, s			28f. Location (	Street and Nu	ımber or Rur	al Route Number,
Ď	after after I Dire d in b	Certification:	4 Homicide determined	building, etc	(Specify)			City or To	wn, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C		ysician: To the best on niner: On the basis of and manner sta	examination and/or						
	Mithin To the To the To the Comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sig	ned (Month	, Day, Year)
			> 7 no			0006	7575		Septon	ber 4	2008
,	200.1		30. Name and address of person who			e. Print)		21 5211			
t	3A5+1		Munna Garg M) 31. Date filed (Month, Day, Year)	11107 Ru	cofruellar's Signature	icerca (	Beran, MD	21811			
	Sta Registi		SEP 0 5 2	008	ar's Signature	hand .					
D11		001		JOSEPH CONTRACTOR	as so f						

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 ear SEPT 1, 1620 WILSON MICHELLE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY Shady Grove Adventist Hosp. Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 2, 1960 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday) Months 1 □ M 2 🔀 F Wash. DC 577-96-0372 47 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County X Yes 2 No Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number

1 ☐ Yes 2 🗖 No

16a. Decedent's Usual Occupation

Cook

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ardent Crematory

21044

(Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

1 - For State Registral

10a State

MD

11. Marital Status

1XX Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

James Wilson

19a. Informant's Name/Relationship (Type. Print)

4 □ Donation 5 □ Other (Specify)

12th

20a. Method of Disposition

5643 Harpers Farm Road, #F

15. Decedent's Education (Specify only highest grade completed)

Valeria Crawford (Niece)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from Staff

12. Was Decedent Ever in U.S. Armed Forces?

1 ∐Yes 2 █️No If Yes, Give Year or Dates:

College (1-4or 5+)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show s 23a or 28a-f show

Director

Funeral

2

Completed

Be

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death with the Maryland

Baltimore, Maryland 21215-0036

burial-tra physician the attending p ed by the detached f signed t has After this death. n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi

Division of Vital Records, P.O. Box 68760.

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Inportant: If tem 27 is marked other than "natural", or iter any laup or other traumatic event, the Medical Exercita SNOWDEN FUNERAL HOME, P.A. matur AF maral Service Licens 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) netgotatio neveatic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Peath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29b. Signature and title of certifier 41162 MD 12

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Germantan MAZC876

M

U.S.A.

14. Race - American Indian,

General Hospital

Approximate Interval Between Onset and Death

Black, White, etc.

Specify: Black

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

1 ☐Yes

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 🕸 6

Year

Month

Hanover, MD

Howard Co

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60004

1904 N. Carlyle Pl, Arlington Hgts, IL

9/6/08

Annie Mae Coakley

State Registrar

DHMH 17 Rev 1/2001

To the within 2

3

Doctori

32. Registrar's Signature

2008

30087 State of Maryland / Department of Health and Mental Hygien () 1 - State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 26 2008 8: 45 AM **Physician** Delores J. Walker /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Futurecare Chesapeake Arnold 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month. Days Hours Min. A Dr. 28 1934 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Marviand 1 □ M 2√2 F 220-30-1064 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **ahow** Item 27 is marked other than "naturel", or Items 23a or 28a-f abov other traumatic event, the Medical Exertaint must be notified at 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Annapolis Direct 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 21401 USA 701 Glenwood St. Apt 521 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: à 3 Nidowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Baltimore permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene Important: if item 27 is marked other than "n any Injury or other traume". Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Educator 12th 8yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olivia Jenkins Joseph Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1819 Johnson Rd. Annapolis, Md. 21409 Clementine Carter(Friend) 20c. Location - City or Town, State 20a. Method of Disposition 200 Place of Disposition (Name of Recold 1 X Burial 2 Cremation 3 Removal from State 9-3-08 4 ☐ Donation 5 ☐ Other (Specify) U.M. Church Cem Annapolis, Md. Williame Reades of Acuisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Jarry J. Rear Moores 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the ettending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760. certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown EMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Accident 5 Pending 1 Yes 2 No death. investigation ofter death Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e Hospital 29a. Certifier 1 💋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AUGUST 26, 2008 57531 msn n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Suite 204, Millysville, Mid 21108 3601 Veterans Hwy mohit Ness 31. Date filed (Month, Day, Ng State O 3 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 U U 8 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Franklin C. Wilson 2008 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital EASTON TALBO EASTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 220-32-5737 71 Director 20,1936 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show if of Health and Mental Hygiene.
If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be modified at Caroline MD Preston Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21655 4635 Cedar Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. -RADKLIN Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No Specify. Specify: à 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Annapolis Auto Parts Elementary/Secondary (0-12) College (1-4or 5+) Parts Driver 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar P. Wilson Mrytle C. Fendlay ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4635 Cedar Place Preston, MD 21655 William H. Wilson/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place Lakemont Memorial 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 03, permit. Page Department o Important: If any injury or once. Davidsonville, MD 2008 Gardens Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 of Juneral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) **Physician** a /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (to consuperior a serior of euc.) Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

24 hours a Funeral I within 2 To the i

Medical

funeral

After 1

after death filled in by the

State

Registrar

Certification: To

(Check only one) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29c. License number

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Easton, M121601

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

MY

Year

1 ☐Yes 2 No

prao

Maryland

White

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Date of Injury (Month, Day, Year)

31. Date filed (Month, Day, Year) SEP 0 3 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 White Violet R /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomi EVINBULA EEGIDNAL MED (State or Foreign 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Director 218-09-2557 10-24-1912 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 11∑Yes 2 No Director MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21804 USA 617 Hammond Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LPN Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Ella Edna Harwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trainonce. Patricia Wise - Daughter 616 Bowman Drive, Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-6-08 Springhill Cemetery Easton, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 23a. Par 1. Enter the disease, or compolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has hear circuit to the Funeral Director. physician and the buriaf-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

32. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 008 Anthony Yedinak J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 9, 1936 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Pennsylvania 179-28-8491 72 Yrs **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modest Exercises or ust be notified at 1 ☐ Yes 2 No Director Maryland Frederick Monrovia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21770 3987 Rye Lane USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2/2/3/No
If Yes, Give
Year or Dates: Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Technical Writer US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Yedinak Remetz Andrew Margaret 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3987 Rye Lane, Monrovia, MD 21770 Georgette V. Yedinak/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Emmitsburg, MD 19/4/2008 Mary's Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 tionlon Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final avduo Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) neumon The law requires that the death certificate be executed physician and s the burial-transit Exami resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical as attending I for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has t page 2 s autopsy performed? Yes 2 10No After this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. To the Funeral Director; After this commentation by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008

Registrar

DHMH 17 Rev 1/2001

State

11

31. Date filed (Month, Day,

lan

arros Rd. Hagestaur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Las Month 12:50PM **Physician** 29, 2008 4c. County of Death KAREN NN August /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) June 13, 1963 **Funeral** 45 Maryland 216-92-4689 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 XYes 2 ☐ No Maryland Prince George's Greenbelt Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 10 T Plateau Place 20770 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify. <u>ک</u> 3 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bus Attendant Montgomery County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Louis Wege Jutta Ingrid Mehrle ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl W. Zoellner -husband 10T Plateau Place Greenbelt, Maryland 20770 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Greenbelt City Cemetery 9/3/2008 Greenbelt, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) cancer ronsmall cell **Examiner** metastatic luna year Singuishment of the cause of th Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death signed by the at 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 Tes Completed certificate has been siç irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: 1 \*\*Inpatient Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2 ER/Outpatient 3 DOA ၉ nours after death.

neral Director; After this of filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide within 24 hours a **To the Funeral D**completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 Omoller 10

Registrar

State

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Meson.

CONNOLLY

4 2008

31. Date filed (Month, Pan Year)

State of Maryland / Department of Health and Mental Hygiene State Amended item#20a,09.05.08, WCHD State of Death 2 Date of Death **Physician** 09 / 03/ <sup>19</sup>2008 00:50 A M Joseph F. Zambon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wochester Atlantic General Hospital Berlin 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1**X** M 2□ I 721-07-5884 80 Director New York 12/17/1927 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Director 1 ☐ Yes 2X No Ocean View DE Sussex 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? PO Box 421, 30955 Sandy Landing Road 19970 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates: Specify à Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than State Policeman Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hamel Zambon Irene (Doyle) Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19970 19a. Informant's Name/Relationship (Type. Print) PO Box 421, 30955 Sandy Landing Rd., Ocean View, DE Janet Zambon / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Eastern Shore 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or c + Burial 2 Coremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/04/2008 Lewes, Delaware Crematorium 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Parsell Funeral Enterprises, 16961 Kings Highway, Lewes, eith 4 23a. Part1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition /Medical as a consequence of Examiner Sequentially list conditions, if any, had in to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1. Inpatient on of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 □Yes 2 □ No 24 hours after death. investigation 2 Accident filled in by the 3 Suicide Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of eand manner state (Check only amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Merr Date filed (Month Day, Year) 's Signature 05 2008 Registrar

700:0050

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last)

Age (In yrs. last birthday,

City, Town, or Location of Death

TIMOTE If Under 1 Year | If Under 24 Hrs.

(17

3. Time of Death

30

9. Birthplace (State or Foreign

2008

4c. County of Death

N/A

otember 14

**Physician** /Medical **Examiner Funeral** Director

VALERIE ANDERSON-JOHNSON

4a. Facility Name (If not institution, give street and number)

death with the Maryland ral", or items 23a or 28a-f show Evaning must be notified at "natural"

filed within 72 hours after tímore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other treasmant.

Physician /Medical Examiner

physician and s the burial-trans attending p for use as t the by pade certificate ! After this of funeral din eral Director: A

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Date of Birth (Month, Day, Year Min 1□м 2Д Б 2-14-1956 MARYLAND 212-70-9071 52 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State MD. N/A BALTIMORE 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 757 LENNOX ST. APT B 21217 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ∐Yes 2 X No Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -11--0-MADISON PARK DAYCARE ATDE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES E. CHEEK EARLENE CHEEK ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 757 LENNOX ST. APT. B BALTIMORE, MARYLAND 21217 WILLIAM JOHNSON (HUSBAND) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 Removal from State BALTIMORE, MARYLAND METRO CREMATORY 9-22-2008 4 ☐ Donation /5 ☐ Other (Specify) HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. 21. Signature of Funeral Service 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death 23a. Part 1. Fiter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediat / Cause (Final disease / ondition resulting in death) Due to (or as a consequence of): erknsion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Tyes 2 TNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 3 Probably 4 Unknown 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 □Yes 2 🗖 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Begistrar's Signatur 40 Year) 31. Date Wed (Month, Day, State

Registrar DHMH 17 Rev 1/2001

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Year Month **Physician** EROME 2008 /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner altimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 1 → M 2 □ F 214-72-4747 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 14 Tes 2 □ No Director altimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zin Code <u> 213</u>34 rofton Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 ☐ ★6
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐ No Black Specify Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Hotel aundr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun Baltmore, MD 21239
Date 20c. Location - City or Town, State Robin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 19-2008 Baltimore, MI 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaugnon C. Greece Funeral 21. Signature of Funeral Service License SERVES YORK AND BOUTINDIE, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Illracrau **Physician** ) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine law requires that the death certificate be executed and burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No the detached 9 Unknown 9 Unknown Ď. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerformed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After **+** ☐Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after dea.h. To the Funeral Director 2 Accident 6 ☐Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n by 4 Homicide completely filled 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

4

Saltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State S Registrar

31. Date filed (Month, Day, Year)

30. Nam an

32. Registrar's Signature

address of person viho completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

301

08-07003 Des

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

shawna Brown 1-Fo	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No.  2 0	08 3009						
Physician/ Physician/	De Shous no Prown 2. Date of Death Month Day Year September 13, 2008	3. Time of Death 1556 hrs						
<b>4</b> a.	Facility Name (if not institution, give street and number)  Johns Hopkins Hospital Ped. E.R.  Baltimore							
	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Bir	thplace (State or grantry) MD						
Åi 10a	ual Residence of Decedent a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 No						
Maryland 28a-f show d at once.	e. Street and Number  106.11.9. Cacil Avo avo a 21218  109. Citizen of What Cou							
	Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - Ame White, etc.	rican Indian, Black,						
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5-0036 ed within 72 hour olygiene. he-Medical Exar	Elementary/Secondary (0-12)  College (1-4 or 5+)  Donestic  Prive   te							
21215-0036 Juld be filed within 7 Mental Hygiene. merked other than re event, the Medica To Be Compile	7. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	te, Zip Code)						
e, MD 21 I and 2 should! Health and Mer item 27 is man r traumatic ev	Delegation Place of Disposition (Name of cemetery, Date 20c. Location - City of Disposition (Name of cemetery, Date )	or Town, State						
Pages I nent of H	Burial 2 Cremation 3 Removal from State Crematory or other place)  Donation 5 Other Specify:  Donation 5 Other Specify:  Donation 5 Funeral Service Ligensee  2 The and Address of Facility  The specific Cremation of Funeral Service Ligensee  Removal from State Crematory or other place)  Address of Facility  Removal from State Crematory or other place)  Removal from State Crematory or other place)	Services						
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E Xa	Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  X UNPENDED  AMENDED 23a,27,perME, g885 11/13/08 TT							
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Division of Vital Records, P.C rat or Attending Physician: The law requires that is after death.  All Director: After this certificate has been signed led in by the funeral director, page 2 should be detical in by the funeral control of the detical cartification: To Be Completed by	autopsy prior performed? death	to completion of cause of						
Vital Recysician: The linis certificate director, page	25. Was case referred to medical 26.Place of Death (Check only one)							
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Division o Spital or Attending sours after death. neral Director: After filled in by the fune Certification:	1 X Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of or Town, State)	r Rural Route Number, City						
Division To the Hospital or Attend within 24 hours after death To the Funeral Director- completely filled in by the	4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as (Check only Check on Check only Check on C	stated. to the cause(s)						
To the Hos within 24 b To the Fur completely	29b. Signature and title of certifier  29c. License number  29d. Date signed  September 1	(Month, Day, Year)						
	30. Name and address of person who completed cause of death (Item 23a)							
State	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, IVID 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature							
Registrar	SEP 1 9 2008 ORIGINAL							

_		1 - State Registrar		Cer	tificate of	Death		Reg. No. 2	
Physic		Decedent's Name (First, Middle, La     ROSA BERTUCA				2. Date of Dea Month SEPTEM	BER 17,	3. Time of Death 2008 3:06 A.M	
	/Medical Examiner  4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County	
	Genesis Eldercare - Brightwood				Bright			Bal	timore
Funera Directo			Sex 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 9/2/19	y, Year)	9. Birthplace (State or Foreign Country)  Italy
yland now		10a. State 10b. County	10c. City	y, Town or Lo	cation		-		10d. Inside City Limits
Mary a-f sh	ctor	MD BALTI	MORE	LUTH	ERVILLE				1 ☐ Yes 2 ☐XNo
or 28	Director	10e. Street and Number	•		10f. Zip Code			10g. Citizen of V	What Country?
s 23a	eral	1 SPRING HOUSE	ROAD 12. Was Decedent Ever in U.	0 140.1	210		anife Van or Na	US	A e - American Indian,
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ise, Initially Initial ZELZ ISCOSO  I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)			king	16b. Kind of Bu	usiness/Industry
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il Hyginal Hyginal Action	Be C	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	ne (First, Middle,		
should be ind Menta marked umatic ev	5	SANTO CREA				FRANCE	SCA BOVA	i.	
2 should be filed we hand Mental Hygie is marked other traumatic event, In		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailin	ng Address (Street	t and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip Code)
1 and 2 Health tem 27		FRANCES CARSON /. 20a. Method of Disposition			PRING HOL		LUTHERV Date		D 21093 City or Town, State
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/Medical Examine		resulting in death)	Due to (or as a consequ		,				
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octificate be executed inding physician and use as the burial-transit	fedical Examiner	IF FEMALE:	a.  Due to (or as a consequence)  Comment  Due to (or as a consequence)  Comment  Due to (or as a consequence)  Comment  Due to (or as a consequence)  d.	ancy			lure	23d, Da	ate of delivery
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To the Hospital or Attending Physician: The law requires that the death certificate hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnat at Live birth 2 Feta Pregnant at time of c 9 Unknown  Contributing to death but not residual.  Hospital: 1 Inpatient 2 2  28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At he building, etc. (Specification). To the best of examiner and manner stated.  Physician: To the best of my known and manner stated.	ER/Outpatier  28b. Time of Injury  Dome, farm, str	Determine the factory, office	ven in Part I.  26. Place of Deather: 4 Nursing Hury at rk? 1Yes 2 No	23e. Did t  1	obacco use con Yes 2 No an Dosy Permed 2 2 No dence 6 Ott how injury occur  Street and Number win, State)	tribute to the cause of death?  3 Probably 4 Punknown  Were autopsy findings available prior to completion of cause of death?  1 Ves 2 No  ner (Specify)  red  ber or Rural Route Number,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rd

Stz 106

32. Registrar's Signature

Philadelphia

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

signed by the a

After this certificate has funeral director, page 2:

after death.

I Director: Af d in by the fur

within 24 hours after

To the Funeral Dire

completely filled in b

Approximate Interval Between Onset and Death Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Beath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 HNatural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifis **2008** D005702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

3. Time of Death

9. Birthplace (State or Foreign

West Virgini

10d. Inside City Limits

MD 21221

1 ☐Yes 2 XNo

942 PM

Year

2008

USA

Specify:

Baltimore

14. Race - American Indian, Black, White, etc.

White

State Registrar Ball MD 21237

DR

RITA

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 18, 2008 **Physician** 2:30 A M Mary Kathryn Bailey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Overlea 7001 Beech Avenue 8. Date of Birth (Month, Day, Year) April 4,1958 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 1□ M 2 🖁 F Months Days Hours 50 214 72 9932 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or Items 23a or 28a-f shov Exerciper must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Overlea 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21206 7001 Beech Avenue by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 24 No Specify: "natural", or Specify.White 3 ☐ Widowed 4 ☐ Divorced Completed is marked other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) Hospital Pharmacy Lab Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Duchacek Loskot Margaret Edward Moran ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any Injury or other trau (husband) 7001 Beech Avenue Overlea, Maryland 21206 Mark Bailey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory Inc. 9/19/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a. Patt1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC GASTNIZ /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiel ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D0066507 MYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIMISH PANDYA, MO

Baltimore, Maryland 21215-0036

Box 68760,

Ö

Division of Vital Records,

State Registrar

UNIVENIN

31. Date filed (Month, Day, SEP 1 9

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MA

2 CIVEENE

22

32. Registrar's Şignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Jeannette Theresa Belzner /Medical 4c. County of Death 4b. City, Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 11110 If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, yrs. last birthday 5. Social Security Number 6 Sex Year) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 75 213-30-0205 Marvland 11/02/1932 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County d other than "natural" or Items 23a or 28a-f sho event, the Medical Examiner must be rigitlied at 1 ☐ Yes 2 X No Baltimore Middle River MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21220 U.S.A. 1303 Washington Irving Lane **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married , o. 1 □Yes 2X No Specify. Specify: White δ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) At Home Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. Homemaker Health and Mental Hygi em 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evone. Victoria Kozlowski Francis Bonkowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3811 Rolling Way Baltimore, MD 21236 Steven Belzner/ Son 20b. Place of Disposition (Name of Cometery Crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/22/08 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, MD Cemetery 4 □ Ponation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm Jate Cause (Final Physician dis se or condition the ling in death) /Medical Due to (or as a consequente of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t irector, page 2 s 2 No 1 □Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this c 1 Yes 2 No Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

Re Funeral Director: A pletely filled in by the fi 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

2008

DHMH 17 Rev 1/2001

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Margaret T. Bienert /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. Birthplace (State or Foreign Country) Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F 90 215-16-1739 09-21-1917 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at anones. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2√ No Director MD Harford Forest HI11 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1713 K Landmark Dr 21050 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: White 2 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent C. Geppi Giovannia Messina 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore J. Bienert (Son) 211 Holstein Ct Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09-19-2008 Dulaney Valley Mem. Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee 610 W. MacPhail Rd Bel Air, MD 21014 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9□Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 Probably 4 □Unknown 1 ☐ Yes 217116 Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 2 100 1∏ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tyes 2<u>⊟ No</u> 1 | Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending investigation 1 Yes 2 No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

6

30. Name and address of person who completed cause ordeath (Item 23a) (Type, Print)

2008

19

Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Baltimose, MD

Street

32 Registrar's Signature

South Hanover

2008

Zaw MIN

31. Date filed (Month, Day, Year)

SEP19

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 18 18 2008 **Physician** Henry Cahill Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7942 Queens Road Glen Burnie Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 579-38-5426 80 Sept.14, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show other traumatic event, the Michael Exeminer must be notified at 1 Tyes 2 No Director Glen Burnie Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7942 Queens Road 21061 U.S.A. items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No White ρ Yes. Give Specify: 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Im. M. Writer & Artist Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Henry Cahill Sr. Elizabeth Stock ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Mary Kindrat/ Daughter 7942 Queens Road Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept. 17. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 4 □ Donation 5 □ Other (Specify) 2008 Glen Burnie, MD 22. Name and Address of Facility Singleron Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INFARCTION MYOCARDIAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Month Day Ye aı in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Hlnknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 **N**0 3 ☐ Probably 4 ☐ Unknown Completed been AILURE TO THRIVE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 □ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No this Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SEPTEMBER 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) millerville no 2/108 Swite 204 86 al Veterans Hwy 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07062 2008 30103 State of Maryland / Department of Health and Mental Hygiene Mario Pido Caramanzana Certificate of Death 3. Time of Death 2. Date of Death Registrar

1. Decedent's Name (First, Middle,Last) 0950 hrs Physician/ September 15, 2008 Mario P. Caramanzana ' Examiner Meg! 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Cockeysville 35 Spring Glen Court 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Foreign 5. Social Security Number 11/24/1970 **Funeral** Min. Hours Months Days 37 618-08-3255 1 X M 2 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Oh County 1 Yes 2 X No Cockeysville Baltimore MD 28a-f show once. 10g, Citizen of What Country? 72 hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number Philippines 21030 35 Spring Glen Ct 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married <sub>Specify:</sub> Asian Yes 1 Yes 2 No specify: If Yes, Give Year Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done δ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed bentir Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natingury or other traumatic event "..." the Medical Exa College (1-4 or 5+) Elementary/Secondary (0-12) Nursing Registry Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Preciosa Pido Conrado Carmanzana Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 E. Joppa Rd. #410, Towson, MD 21286 19a Informant's Name/Relationship (Type, Print)
Sheila Marie Carmanzana/ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Beltsville, MD 9/18/08 Chesapeake Crem. Donation 5 Other Specify 22. Name and Address of Facility CAFA/Stephen D. Lohrmann PA 21 Signature of Funeral Service Licensee Green Pastures Dr. Towson, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician Death failure. List only one cause on each line. **Medical** Pneumocystis carnii pneumonia Immediate Cause (Final disease \_kaminer Due to (or as a consequence of): or condition resulting in death) Human Immunodeficiency Virus (HIV) infection Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit AMENDED PI line a-b, 27, per ME G884 10/2/08 TT X UNPENDED attending physician or use as the burial -23d. Date of delivery P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Fetal death Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

has been signed by the att 2 2 should be detached for certificate h

Division of Vital Records, re Hospital or Attending Physician: T n 24 hours after death. re Funeral Director: After this certifica pletely filled in by the funeral director, p To the I within 2

Physician/Medical ğ Completed

Medical Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) SEP 1 9 2008 State Registra

3

Suicide

Homicide

25. Was case referred to medical Be Hospital: 1 examiner? 1 🗸 Yes .28a. Date of Injury (Month, Day, Year 27 Manner of Death Certification 1 X Natural Investigation 2 Accident

Certifying Physician: To the best of my inowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)

6 Could not be

determined

Assistant Medical Examiner 32. Registrar's Signature

Inpatient 2

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

26.Place of Death (Check only one)

Other

Yes 2

28c. Injury at Work?

ORIGINAL

ER/Outpatient 3

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

DHMH 17 Rev 1/2001 **OCME 2006** 

DOME

Yes 2 No 3 Probably 4 🗸 Unknown

death?

28f. Location (Street and Number or Rural Route Number, City

September 16, 2008

29d. Date signed (Month, Day, Year)

1 🗸 Yes

24a. Was an

✓ Yes 2

or Town, State)

autopsy performed?

Nursing Home 5 Residence 6 Other: Scene

28d. Describe how injury occurred

24b. Were autopsy findings available

prior to completion of cause of

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:5PM 3008 10 9 /Medical a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth Month, Day, Sing Home 7. Age (La)rs. last birthday) M O C 9. Birthplace (State or Foreign 6. Sex Security Number Funeral Months Days Hours 1□M 2KF Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Ітете 23а Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Even Armed Forces?
1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Yes, Give A Specify: Specify: þ 3 Widowed 4 Divorced 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other then any folury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 0 Se 19a. Informant's Name/Relationship (Type, Print) daughtes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and A Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart follure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed ettending physiclen and for use as the burial-translt Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year signed by the e 5 Other (specify) 1 ☐ Yes Z 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificete has autopsy 2 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one ZINO Hospital: Other: Medical Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certif 29d. Date signed (Month 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 148161475

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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2008

32. Registrar's Signature

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IMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9-16-2008 Year 6:00P Warren E. Eckhart, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balto. Oakcrest Care Center Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-3-1925 9. Birthplace (State or Foreign Country) Md.• 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days **1** M 2□ F Hours Min. Months 83 219-16-4970 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2√ No Parkville Md. Balto. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 8800 Walther Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Y☐Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married Specify: White 1 □ Yes 💥 No If Yes, Give Year or Dates: 3. Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Master Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia A. Smith George F. Eckhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3525 Lower Mill Ct. Elliott City, Md. 21043 Son Warren E. E<u>ckhart,Jr.</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State 9-22-2008 Most Holy Redeemer Balto. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral House 21. Signature of Funeral Service Licenses 9705 Belair Rd. Nottingham, Md 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Senal resulting in death) Due to (or as a consequence of): ongestive heart Sequentially list conditions. Due to (or as a onsequence of): ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Severe pulmonary
Due to (or as a consequence of): Sitical aprtic stenosis 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Asplasia, stage 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown IV Chronic Kidney 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

è

Be Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Mortes Examine must be muffled at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Completed by Physician/Medical

Be

Certification: To

Medical

State

Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

coronary artery

1 Yes 2 No

5 ☐ Pending investigation

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 ☐ Could not be 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

29b. Signature and title of certifier

27. Manner of Death

1 Naturai

2 Accident

29c. License number

29d. Date signed (Month, Day, Year)

MP 30. Name and address of person who completed course of death (Item 23a) (Type, Print) D61785

21 ther Blud Partville MD 21234 MD Vixon

31. Date filed (Month, Day, Year) SEP 1 9 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician 9:38 AM 2008 LUCILLE IRENE FOY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE SAMARITAN HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Min Days Hours 1 □ M 2 □ F 214-14-5561 88 JUNE 13, 1920 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE PERRY HALL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9107 LINCOLNSHIRE CT IINTT B 21234 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No WHITE Specify Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygient Important: If Item 27 is marked other than any Injury or other trailmests. Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL CREDIT MANAGEMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN BARTLETT LENA KAPPES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) CAROLYN VARINSKI-FRIEND 9107 LINCOLNSHIRE CT BALTIMORE, MD 21236 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 9/19/08 4 □ Donation 5 □ Other (Specify) GLEN BURNIE, MD ure of F neral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 m 23a. Part1. Enter the disease, or commencations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) SEPSIS **Physician** day /Medical Due to (or as a consequence of): Examiner UTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, the death certificate be Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an  $\mathcal{I}$ 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Year (Month, Day 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title HYSICIAN 0051024 09.18.2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Romeus Raven Boulevard 21239 Wids 5601 Loch R. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Gilbert btember 18 2008 Jo-Ann Ruth /Medical 4a. Facility Name (If pot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/02/1943 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1 M 2 X F Months Hours Min. 64 Director 212-42-0903 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 200. Other traumatic event. The Market and Injury or other traumatic event. The Market and Injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland Baltimore Essex 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1108 East Riverside Avenue 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ X o If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ZNO Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Minister Religeous 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Walter Wilson, Sr. Pauline Borleis ပ 19a. Informant's Name/Relationship (Type. Print) (Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1108 East Riverside Avenue, Essex, Maryland 21221 Mary Ann Sarah Umberger 20a. Method of Disposition
1 □ Burial 2 ★ remation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bayview Crematory, Inc. 09/22/2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility of Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 r in 1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MOXIC DW , /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 🔲 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform rmed? 2 ☑ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\Delta\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 □ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manyfer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Maccident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, hours after death uneral Director: filled in by the To the Hospital within 24 hours a To the Funeral C Hospital

> State Registrar

(Check only

30. Name and address of

29b. Signature and ttle of certifier

person

Year) 2008

MIC

Day.

one)

MD

who completed cause of death (Item 23a) (Type, Print)

32. Registrats Signature

de

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

trank

29d. Date signed (Month, Day, Year)

2008

- State Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	Funeral Director	
Maryland	fshow	

and 2 should be filed within 72 hours after death with theatth and Mental Hygiene. m 27 is marked other than "natural", or Items 23a or

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Helen ard ner 3008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. DAL TIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Security Number 1 □ M 2 💢 F Months Days Hours Min 217-36-333 une 10 1919 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 □ Yes 2 🗖 (Vo **Funeral Director** BALTI MORE MD ARKVIlle ortant; If item 27 is marked other than "natural", or items 23a or 28a. Injury or other traumatic event, the Medical Examination to the 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ rainia nru 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 3499/ permit. Pages 1 and 2 s Derentment of Health a Important: If item 27 is any Injury or other trau 20a. Method of Disposition al b lerrace ughter NO Olympic 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, Stay Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Fadlity 21. Signature of Funeral Service Licenses BALTIMORE, AD 21234. Eveins Frincial Chape I+1 REMATION SERVICES PARKVIlle ΛÒ( or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise shock, or heart failur. Immediate Cause (Final disease or condition resulting in death) MICER ann Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi Due to (or as a consequence of) Physician/Medical sate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Dense 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 1 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No within 24 hours after death To the Funeral Director: neral Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fxelto. Md 21204 6701 Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 5:15 Cecilia R. Giese September 17,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F Director 11/28/1930 218-26-2162 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Baltimore Middle River 1 ☐Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 836 Luthardt Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Completed by If Yes, Give Year or Dates: Specify Specify: White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Companion 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Phillips Cecilia Crovo ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Giese, Jr./ Son 811 Cedar Grove Rd. Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place).

Gardens of Faith 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 09/22/08 Rosedale, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** METASTATIC SARCOMA OF PELVIS sease or condition sulting in death) UM-ARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D64395 SEPTEMBER 17,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHAPIES ST, 84172 209 BALTIMARE, MO 21204 DANIEUX DOBERMAN, MO

Registrar

State

31. Date filed (Month, Day,

Box 68760.

P.0.

Division of Vital Records,

32. Registrar's Signature

Amend 16a-b, 18 per Fn good 2/3/09 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G884 10/28/08 JH
State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death 2008 **Physician** DIOMBOWSK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 'ARICVI LUE BALTIMORE ourt Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex. 1 M 2 ☐ F **Funeral** Days Hours Year) DALTIMORE, WO Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantice must be notified at 1 □Yes 2 No Directo JI MOR 10e. Street and Number 10g. Citizen of What Country? ala Funeral 12. Was Decedent Ever in U.S. Armed Forces?, 1 \( \text{Yes}, \) Give Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>م</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Manager (Specify only highest grade completed) **Collections** permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 Is marked other than "any Injury or other traumatic event, the Mesone. College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden, Rykowski 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 120/08 FOREST HILL MD -ORD CD, BALTIMOLE, MD 21234. Del+CREMATION Services Parkville Evans Funcial Chapel 21. Signature of Funeral Service Licensee s that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest is on each line Approximate Interval Between 23a. Part 1. Enter the disease, o shock, or heart failure. Lis complicationly one Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 montu /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçço use contribute to the cause of death? Division of Vital Records, ۾ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 3 🗌 Suicide Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number D4-14-0 6 29d. Date signed (Month, Day, Year) Sept 1872 208 BALTIMORE 30. Name and address of person who completed cause of death (theq) 29a) Type. Print) 21204 31. Date filed (Month, Day, Year) 82. Registrar's Signature State SEP 1 9 2008 Registrar

# filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician  $_{\rm P}^{\,\sf M}$ JUNE R. GEYER SEPT 2:10 6, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 / 27 / 1918 Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) Days 1 □ M 2 🔀 F 90 Director 172-05-1405 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 24 N. COURT ST. 21157 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No 3X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) 1 2 College (1-4or 5+) SECRETARY TOURIST CENTER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be CHARLES JOSEPH STROSSER FLORA D. BOWMAN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NEAL HOFFMAN 24 N. COURT ST., WESTMINSTER, MD 21157 - ATTORNEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) PLEASANT VALLEY CEM. 9/19/08 PLEASANT VALLEY, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, and rt failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months2 Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Depatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OR Foundam B. Kaneug 349 Wertminer MD 21157 Year) 2008 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

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For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 28 2008 2008 **Physician** 3:31 PM M Diane F. Hoffman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery 705 Garden View Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 29, 1945 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days Months Hours 1 M 200 F Kansás 510-48-4931 62 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend ment of Health and Mental Hygiene. The tree 23e or 28e-f ehow shit if item 27 ie marked other then "neturel", or iteme 23e or 28e-f ehow ury or other traumatic event, it is Medical Excitor marked collection at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20850 705 Garden View Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wayne Waxford Williams Helen Carrie Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
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eny injury or other trau Kevin M. Hoffman/son 6005 Pinehurst Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicensee Romand S. Wades State Anatomy Board 655 W. Baltimore Street rector m 21201 Baltimore, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 yrs Jung cancer

Due to (or as a consequence ol): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificete has b lirector, page 2 sl 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2□No director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Yes 2 HO this Director: After that in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 2 Accident 6 Could not be 3 Suicide 28e. Place ol Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 | Homicide within 24 hours aft To the Funerei Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D45880 September 10, 2008 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) Hwang Shady Grove Medical Center 1396 Piccard DR. Rockville, Md. 20850 Leòn 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Spell SEP 1 9 2008 Registrar

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2	9a. Certifier 1 CertIfy (check only one) 1 Medic	ing Physi al Examin	er: On the ba	asis of exami	nowledge, on nation and/	death occurre or investigation	d at the tim on, in my op	ne, date and p pinion, death o	occurred	due to the c at the time, c	ause(s) date and	and manner I place, and o	as stat due to 1	ed. he cause(s)	
2	9b. Signature and title of certif	er	w	MD		29	RES	number	0	2	9d. Date	e signed (Mo	nth, Da	y, Year) 2008	y
3	D. Name and address of person	n who coi	mpleted caus	e of death (I	tem 23a) (T	ype, Print)		60	00 No	rth Wol	fe Si	. Baltin	ore	MD. 212	87
3	1. Date filed (Month, Day, Year, SEP 1 9	2008	32. Re	gistrar's Sigi	hature	2066)						-,		,,	
	2 2 2 1 Indian Report 1 2 2 2 2 2 2 2 2 2 2 3 3 3 3 3 3 3 3 3	1. Decedent's Name (First, Mid Decedent's Name (First, Mid Decedent's Name (First, Mid Decedent's Name (First, Mid Decedent's Name (First, Mid Decedent's Name (First, Mid Decedent's Name (First, Mid Decedent's Name (First, Mid Decedent's Name (First, Middle Arthur Ferding's Name (First, Middle Name (First, Middle Arthur Ferding's Name (First, Middle Name (Fir	1- State Registrar  1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give some condition)  5. Social Security Number  280-34-3354  Usual Residence of Decedent  10a. State  10b. County  MD  Montgom  10e. Street and Number  7314 Holly Avenue  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Arthur Ferdinand  19a. Informant's Name/Relationship (Typ. Josephine J. Hoge/  20a. Method of Disposition  1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenser  About 12 Montain Some (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  27. Manper of Death Natural 5 Pending investigation a survey of the conditions conditions are sulting in death) Last  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manper of Death Natural 5 Pending investigation of Could not be determined  28a. Certifier Certifying Physic Certifier  29b. Signature and title of certifier  29c. Certifier Certifier  29a. Certifier Certifier  29b. Signature and title of certifier	State   Colored   Property   Print   State of Maryla   State   State   State   State   State   Registra	State of Maryland / D Registrar  1. Decodent's Name (First, Middle, Last)  DEAN Second Security Number   Second Security Security Security Security Security Security Second Security Securit	State of Maryland / Department	State of Maryland / Department of Integration   Certificate of II   Page   Certificate of II   Department   Certificate of II   Ce	State of Maryland / Department of Health at Certificate of Death  1. Beathers  1. Decadent's Name (First, Micdife, Last)  1. Decadent's Name (First, Micdife, Last)  1. Decadent's Name (First, Micdife, Last)  2. Social Security Number  2. Boolal Security Number  2. Social Security Number  3. Social Security Number  3. Social Security Number  2. Social Security Number  3. Social Security Number  4. Social Security Number  3. Social Security Number  4. Social Security Number  4. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex Vary In Unider 24 Was Decadent Ever in U.S. Armed Forces?  1. Social Security Number  2. Social Securit	State of Maryland / Department of Health and Me Certificate of Death  1. Decodent's Name (First, Micrito, Designer and number)  The Johns Hopkins Hospital  3. Social Security Number  1. Media Status  1. Security Number  1. Secur	State of Maryland / Department of Health and Mental Hys. Certificate of Death   Certificate	State of Maryland / Department of Health and Mental Hygiene Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions / Certificate of Death Regions of Death Regions / Certificate / Certificate / Cert	State of Maryland / Department of Health and Mental Hyglene 2 0 0	Conserved belower (first, Modelle, Lest)   Conserved below (Lest)   C	State of Maryland / Department of Health and Mental Hygiene 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	

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SMEND of MENT 250 PDEBLY Sheet 88 Flee of hearth and wenter that Hydiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Catherine Ellen Hanley September 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 1, 5. Social Security Number **Funeral** Days Hours Months 1928 072-22-0777 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show XXYes 2 □ No ir than "natural", or items 23a or 28a-f shifted Medical Evaninar must be notified. Director Brook1vn New York Kings 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 11203 599 E. 37th Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. HANLEY CATHERINE 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 27☑No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Auto Dealership permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If Item 27 Is marked other than any Injury or other traumatic event, Its once. Book Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Hayes James Andrew Hanley Nora ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 599 E. 37 Street Brooklyn, NY 11203 Nora O'Regan/ Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/18/2008 Brooklyn, NY Holy Cross Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1/4 occirclian **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Virs after death. eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a, Certifier 1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Funer completely file 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MDD61131

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

31. Date filed (Month, Day, Year)

SEP 1 9 2008

8118

Good Luck Road Lanham, MD 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician 1230 HESTEN. GLONIA 2008 5 LY DAMSEN /Medical 4a\_Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F Director 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Wedical Evaning must be notified at 1₽Yès 2□No Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Iter 1 Never Married 2 Married ☐Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 □Yes 2 No Completed by 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) dary (0-12) College (1-4or 5+) dlep 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last Be 0.00019b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Poad, a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest Immediate Cause (Final Physician MYDUMBUR WEMLTION MINUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DI ZVNVNMY M 11m if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical as the IF FEMALE: use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 I Inknowé 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown LEDD SINGLE RENALDISENSE should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No MITTHIOSLUMOTIC CONDIDURSULM DISTAGE 24a, Was an page 2 After this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending investigation s after dea... 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

24 hours a vithin 24 hound To the Fune completely file

> State Registrar

NENGROPE 1. 31. Date filed (Month, Day, Year) 2008 9

29b. Signature and title of certifier

MD SCOTT 5601 LOUR NAMEN BLID, BANTMING, MD 21239 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

15135

29d. Date signed (Month, Day, Year)

SEMPLANGEN 15, 2001

Please Type or Print in Black Indelible Jpk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:49 P M September 14 2008 Grace Μ. Hoenig /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Chesapeake Hospice House Linthicum Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aptil 05 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 1911 213-30-9395 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventinal must be marified at once. 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8406 Bodkin Avenue USA 21122 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Robert Bottomly Elsie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alfred Hoenig (spouse) 8406 Bodkin Avenue, Pasadena, MD 21122 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 18 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Medowridge Cemetery 2008 Elkridge, Maryland 21. Signature of Funeral Service Licens Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1 Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) Agate Ger monto **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
E Hours after death.
E Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, 🌣 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 🔲 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □ Yes 21 1 □ Yes Mogpice House 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in an anti-land death occurred. 29a. Certifier Medical within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 6 and address of person who completed cause of death (Item 23a) (Type, Print) Russell DeLuca M.D. 301 Hospital Drive, Glen Burnie, MD 21061

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

9

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 4a per doc g883 9-19-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 16 2008 **Physician** 1:15 RUSSELL HANCOCK STUART /Medical 4c. County of Death 4a. Facility Name (If not institut 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL SEVERNA PARK HOUSEHOLD OF <del>LIVING</del> ASSISTED LIVING Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/22/1916 5. Social Security Number Sex 1 Ø M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Months 041-18-9987 91 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantinet must be notified at once. 1 ☐ Yes 2 X No MD ANNE ARUNDEL SEVERNA PARK Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 118 ARUNDEL BEACH ROAD 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No District Street Str Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married WHITE 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. <u>م</u> 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CHRISTMAS CLUB CORP. SALESMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANDREWS HANCOCK ELIZABETH CLARENCE ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 390 SOUTH DRIVE, SEVERNA PARK, MD 21146 ROSE PRISCILLA Н 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 09/17/2008 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part I/ Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumon Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No r this certificate had director, page 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) A SS/572 Hospital: 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To To the Funeral Director: After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1/Naturai 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crof E 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, og S Day Month 15 lackson **Physician** A M 22 1mE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If pot institution, give street and number) Examiner Baltimore 5. Social Security Number Siche If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours Months 1 □ M 2 F 0 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1XYes 2 □ No MD Baltimore Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number tiEld 21212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No <u>ک</u> Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DD NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) tomemak 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( avrie ပ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drive MIECE 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4 Donasion uneral Service Licensee 21216 ·North 23a. Part1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** QJ8p49991 CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 WNo Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8200 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RiBiJUUJ 828 Entrad Steet Baltinone Anlene Nos th 3a. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 1 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 21:55 PM september 12 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE AGNES SAINT 8. Date of Birth Month, Day, Year) Feb. 25, 1958 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 😿 F 063-50-18 New Director Usual Besidence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at 1 Yes 2 No Director more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life; DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event, the Mod ones. Elementary/Secondary (0-12) omemake 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ 19b. Mailing Address (Street and Number or Rural 19a. Informant's Name/Relationship (Type. Print) musicand Route Number, City 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License r1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart trillure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu Imme late Cause (Final disease or condition resulting in death) interstitial **Physician** month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off vate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑ No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ot 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Vandana

2008

VANDAMA

SEP 19

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGIRI

32. Registrar's Signature

DHMH 17 Rev 1/2001

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20655

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CATON AVE BALTIMORE MD 21229

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 4:30P **Physician** Gomatam V. Jagannathan 9-162008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Balto. Nottingham 11 Treadway Court 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea. 6-18-1945 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1∏ M 2□ F Months 63 Director 092-68-3420 Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f shov Experiment must be notified at 1 ☐ Yes 2 No Director Nottingham Balto. Md. the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amportant: If item 27 is marked other than "natural", or items 23a or ampiriury or other traumatic event, the Modeal Economic nast be none. 21236 USA 11 Treadway Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give specify: Asian-Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Ye ar or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bromrose Corp. Scientist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Radha Krishnaswamy Veeraraghavan Jagannathan ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Treadway Court Nottingham, Md. 21236 Geetha Jagannathan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 9-19-2008 Balto. Bayview 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mucardial Minuites **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Dial if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi sertension Due to dr as a consequence of): Division of Vital Records, P.O. Box 68760, egus slloidemia Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 \( \subseteq \text{ Nursing Home} \) Hospital: 1 Yes No 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours aff e Funeral Di eletely filled ir Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely f (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MO PhD (Item 23a) (Type, Print) 30. Name and address of person who completed cause of de OI 1838 Pikesville MD 32. Registrar's Signature 31. Date filed (Month, Day, State 2006 Calific Registrar

08-07086 William Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day Year September 16, 2008 Physician/ 1653 hrs Medical Examiner WILLIAM JONES, JR. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** Sinai Hospital 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Min. Country MARY LAND Director 2-13-1944 212-42-6574 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County in. 10a. State 1 X Yes 2 No MD. N/A BALTIMORE s 23a or 28a-f show notified at once. 28a-f show death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA 4036 EDGEWOOD RD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status must be Armed Forces? Never Married 2 Married 2 X No Yes Specify: BLACK Yes 2X No specify: 4 X Divorced f Yes, Give Year Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 3 Widowed marked other than "natural", ic event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 PAINTER HOME IMPROVEMENT -10--0-18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILLIAM JONES SR. ESTELLE JACKSON Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ٩ it: If item 27 is r VONZELLA L. JONES (DAUGHTER) 4036 EDGEWOOD RD. BALTIMORE, MARYLAND 21215 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation Removal from State 9-23-2008 BALTIMORE, MARYLAND tment c METRO CREMATORY Donation Other Specify HIBN 122. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Licenses NATHAN D. 21. Signature of Fu 1721-27 N. BALTIMORE MONROE ST. 23a. Part I. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Death 'M dical a. Hypertensive Cardiovascular Disease Immediat Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown þ Completed 24b. Were autopsy findings available 24a. Was an certificate has been autopsy prior to completion of cause of performed? death? Yes 2 Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 After this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification 1 V Natural Yes 2 No Director: Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined (Specify) within 24 hours a Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 17, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner al 11 Penn Street, Baltimore, MD 21201 Russell Alexander MD.

State

OCME

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** BARBARA ANN KANE SEPTEMBER 17, 2008 1:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center @ GBMC Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min 1 ☐ M 2 🕱 F Director 54 155-46-9404 21, 1954 New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Expirition must be redfilled at once. TX Yes 2 No Director Maryland Harford Aberdeen 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 486 Windemere Drive 21001 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Administrative Assistant</u> <u>Police Department</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward (nmn) Cilurso Barbara Mathilda Shinn 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Kane / Husband 486 Windemere Dr., Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9-22-08 4 □ Donation 5 □ Other (Specify) Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ma Physician years disease or condition resulting in death) ervier Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burla-transit stely filled in by the funeral director, page 2 should be detached for use as the burla-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 2000 Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Work 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft e Funeral Di eletely filled ir 29a. Certifier pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar APRON J

31. Date filed (Month, Day, Year)

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eptember

N- Charles Si

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wo

6701

32. Registrar's Signature

CHARLES

Sertember 18 2003

08-0664	0
Joseph I	King

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

sepn King		STATE OF IV 1- For State Registrar	laryland / Depai <i>Cert</i>	rtment of He tificate of De		a went	ai nygiene	Reg. No.	200	8 3012
Physicia ledical Examir	n/	Decedent's Name (First, Middle,Last)	NG GD				2. Date of Month	Death Day 30, 200	Year	3. Time of Death 1532 hrs
Carcar Examin		JOSEPH NELSON KI  4a. Facility Name (if not institution, give street		4b. C	ity, Town, or	Location of		30, 200	c. County of Death	1
		Union Memorial Hosiptal  5. Social Security Number 6. Sex	7. Age (In yrs. la		altimore Under 1 Yea	ar If Under	24Hrs 8 Date o	f Birth(MM	/DD/YYYY) 9. Bir	tholace (State or
Funeral Director		212–30–1494 Usual Residence of Decedent			onths Day		Min.	17,	Foreig	
ми	f	10a. State 10b. County	10c. City,	Town or Location						10d. Inside City Limits
daryland 28a-f show 1 at once,	اة	MD	BAI	TIMORE	7			140- 00		1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number	2		. Zip Code 1202			USA	izen of What Cou	nuy:
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	ja		Vas Decedent Ever in U.S rmed Forces?	6. 13. Was De	cedent of Hi		n? ( Specify Yes o Puerto Rican, etc.)	r No-		ican Indian, Black,
er death wi	된	Never Married 2 Married 1 1 3 X Widowed 4 Divorced If Yes.	Yes 2 X No		2 X No		r derto rucari, etc.,		Specify: BL	ACK
ours aft	흵	15. Decedent's Education (Specify only high	es:	16a. Decedent's Us	sual Occupa	tion (Give k		16b.	Kind of Business/	
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, the Medical Examiner	ompleted		ollege (1-4 or 5+)	3	ŭ		ise retired)		DELTVERY	7
5-00, ed with lygiene other th	Som	12TH 17. Father's Name (First, Middle, Last)		TRUCK	DKTAFF		s Name (First, Midd			
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	a	ROBERT KING		1401 11-11 14-	101		AUSTIN	<b>N</b>	Diameter Charles	7:- 0-4-)
and 2 shoul lealth and M item 27 is m traumatic	٩	19a. Informant's Name/Relationship (Type, P JOSEPH N. KING, JR.					ber or Rural Route AVE., BA			21202
re, N s 1 and f Health ff item	-	20a. Method of Disposition  1 Burial 2 X Cremation 3 Re	20b. P	Place of Disposition rematory or other p	(Name of ce		Date		Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify:		ARDENT			09/10/20			
Balt permit. Departi Import injury	ļ	21. Signature of Funeral Service Licensee	Much				WESLEY C		-	
Physician		23a. Part. Enter the disease, or complication failure. List only one cause on each line	ns that caused the death.	Do not enter the m	ode of dying	, such as ca	rdiac or respirator	y arrest, sh	ock, or heart	Approximate Interval Between Onset and
/Medical xaminer	Ì	Immediate Cause (Final disease a. Athe	rosclerolic Cardiova		e		100			Death
		Sequentially list conditions, b								
	Examiner	if any, leading to immediate  Cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence of	):						1
kecuted n and - transit	Exal	events resulting in death) Last Due to	(or as a consequence of	):		-				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	: If yes, outcome of pregr Live birth Pregnant at time of dea	2 Fetal d	eath 3 (Specify)	Ectopic	pregnancy	23	3d. Date of deliver Month	ry Day Year
the deat y the at	Phys	1 Yes 2 No 9 Unknown g  Part II. Other significant conditions contr	Unknown	esulting in the under	ivino cause	given in Pa	rt I. 23e. I	Did tobacco	o use contribute to	the cause of death?
P.O es that t	ā	Complications of Chronic Alco			Tyling datase	9,,,,,,,,,		_		bably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death.  Al Director: After this certificate has been sited in by the funeral director, page 2 should be a possible or the funeral director.	Completed							Was an autopsy	prior to	utopsy findings available completion of cause of
tal Reco	S						1 🗸	erformed? es 2		es 2 No
/ital sician: is certif	a	25. Was case referred to medical examiner?	li:1 Inpatient 2 ✓	ER/Outpatient 3	26.Plac	Other	Check only one)  Nursing Home 5	Resid	dence 6 Othe	er:
1 of Vital Rec Jing Physician: The I After this certificate I funeral director, page	n: To	1 Ves 2 No  27. Manner of Death	Ba. Date of Injury (Month, Day, Year)	28b. Time of Injury		ury at Work			njury occurred	
vision or Attendi after death. Director:	atio	2 Accident Pending Investigation				Yes 2		(0	and Alicebes as D	ural Route Number, City
Division pital or Attenc ours after death teral Director:	Certification:	Suicide Could not be	8e. Place of Injury - At ho Specify)	ome, tarm, street, ta	стогу, опісе	bullding, etc		wn, State)	and Number of N	urai Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier (Check only 1 Certifying Physician: To	the best of my knowledge	ge, death occurred a	at the time, o	date and pla	ce, and due to the	cause(s) a	and manner as sta	ited.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the and r	nanner stated	nd/or investigation,		se number			Date signed (M	
		Patrica Man	ica-Poll	de mo	0.0	.M.E.		Au	gust 31, 2008	3
0		30. Name and address of person who complete	· · · · · · · · · · · · · · · · · · ·		1 Donn C	Street Po	Itimore, MD 2	1201		
( )	ate	Patricia Aronica-Pollak MD.  31. Date filed (Month, Day, Year) 9 2008	Assistant Medical E 32. Registrar's Signatu	En A	Perin S	oueel, Ba				
Regist		CED 1 9 Z000	Jan Jan Brand	4 3						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days 1 □ M 2 🛛 F 174-20-7652 88 MARYLAND 6/6/1920 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No WESTMINSTER CARROLL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21158 USA 1041 HUGHES SHOP RD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1∐Yes 2XNo Specify: Specify: WHITE 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STORE OWNER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDITH E. PHOUTZ JOHN D. ROOP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EDITH L. FABRICK - DAUGHTER 1041 HUGHES SHOP RD., WESTMINSTER, MD 21158 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State NEW WINDSOR, MD 9/20/08 4 Donation 5 ☐ Other (Specify) PIPE CREEK CEM. 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, 21157 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death obstructive Immediate Cause (Final pulmonau SURAN disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death
9 Unknown 5 ☐ Other (specify)

**Physician** /Medical Examiner

death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending

**Physician** 

Examiner

10a. State

MD

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

the Medical

traumatic

1 and 2 s Health ar

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.

Director

Funeral

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Completed

Be

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Baltimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical

burial-tra physician the. attending p been signed by the should be detached cate has t certificate this funeral After t

ş Completed Be Certification: To n 24 hours after death.

e Funeral Director: Aftetely filled in by the fur

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ang-eshur 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe 1 ☐Yes 2 ☐No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 MNo 1∑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

To the

State Registrar

Medical

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and manner stated.

Tu pe 32. Registrar's Signature

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29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

291 STONER AVENUE

informatister manylord

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2008

IY M

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) SEP 1 9 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Marylar				lealth ar <i>Death</i>	nd Me		giene Reg. No.	2000	0010/
		ч	1. Decedent's Name (First, Middle, Last)  2. Date of Death								<del>2 U U č</del>	3. Time of Death	
	Physici /Medic		BILLY ROGERS M	INISH					S				8 5:15 A M
	Examir		4a. Facility Name (If not institution, give					r Location of	Death			County of Dea	th
			300 PLUMIREE RO 5. Social Security Number 6. S		last hirthday)		L AIF er 1 Year		4 Hrs.   8.	Date of Birt		ARFORD 9. Bir	thplace (State or Foreign
	Funeral Director			© M 2 □ F 77	Yrs.	Month	s Days	Hours	Min.	(Month, Da	y, Year)	C	ountry) orqia
	pu ,		Usual Residence of Decedent		ty, Town or Lo	cation							10d. Inside City Limits
	laryla shov	ō											1 ☐ Yes 2X No
	the N 28a-	rect	Maryland   Harford	B	el Air		Zip Code		-		10g. Citiz	zen of What Co	ountry?
	th with	a D	300 Plumtree Road	ā		2	1015				USA		
	r deat ems	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Ded If Yes, s	edent of H	lispanic Origi an, Mexican,	n? (Specif Puerto Ric	y Yes or No an, etc.)		14. Race - Ame Black, Whi	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show theal Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 📆 Yes 2 🔲 No If Yes, Give Year or Dates:			2 <b>7</b> No	Specify:				Specify:	White
9	"natural"; edical Exa		15. Decedent's Ed	lucation	16a. Dece	dent's U	sual Occup	ation			16b. Kii	nd of Business	
215	thin 73 e. an "n Medi	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give life.	kind of v DO NOT	vork done use retired	during most od)	of working				
21	lygien lygien ner th	Son	12		Execu	tive	Vice	Pres.		First, Middle			Construction
Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho to f Health and Mental Hyglene. If Item 27 is marked other than "natu or other traumatic event, the Medical	Be C	17. Father's Name (First, Middle, Last)					Nodie	•			,	
ary.	should nd Me mark mark	၉	Willie Langston  19a. Informant's Name/Relationship (		19b. Mailir	ng Addre	ss (Street					<u>Υ</u> r Town, State,	Zip Code)
	and 2 alth a 27 is er trau		Betty L. Minish	/ Spouse	300	Plur	ntree	Road,	Bel	Air,	MD 2	1015	
Baltimore,	ages 1 and 2 ant of Health t: If Item 27 I y or other tra	1.0	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Bemoval from State	Place of Dispo cemetery, cre	osition (A matory o	lame of r other plac	ce)	Date	Э	20c. Lo	cation - City or	r Town, State
tim	tment tant: jury o	1	4 □ Donation 5 □ Other (Specify	/) Hic	ghview							lston,	Maryland
Bai	permit. Pages Department of Important: If if any Injury or once.		21. Since ure of Funeral Service Licer	1/ 2				ss of Facility uneral				7	21,000
	- 44	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or head failure. List only one cause on each line.								gaon rrest,	, Mary	Approximate	
100	Physician	4 4	Immediate Cause (Final disease or condition	one cause on each line.	No			owe					Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	ence of):	<	)						130113
	Examiner	<u></u>	Sequentially list conditions,	b. Due to for as a consec	uence of:								
/	rted Insit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a consec	prence on								
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68760,	ificate be executed g physician and as the bunal-transit	edical		d					·				
			IF FEMALE:	23c. If yes, outcome pf pregn	anov								1
Вох	death certif e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	al death 3	⊒Ectopic ⊒ Other	pregnancy	У			1	23d. Date of de Month	Day Year
0	the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			ope only/						
s, P.	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying	g cause giv	en in Part I.		23e. Did 1			to the cause of death?
ord	requir een si oould b								_	1 🗆	Yes 2[	Mo 3⊟F	Probably 4 □Unknown
3ec	2 88 2	Completed			<del></del>					24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
a	ate pag		OC Was assessed to distribute							1□ Yes	2 No	1 ☐ Ye	
=	Physician: The this certificate har all director, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 🗆	DOA Oth	or:	of Death (0	Check only		6 □Other (Spe	ecity)
O	F F F	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injui Wor			d. Describe			eary
Sior	Attending r death. sctor: After by the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		,,	М		Yes 2∐N					
Division or Vital Records,	or Att	rtific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, st fy)	reet, fact	ory, office		281	Location ( City or To	Street an wn, State	d Number or F )	Rural Route Number,
	spital ours a neral I	Medical Certification:	29a. Certifier 1 CertifyIng Ph	yslcian: To the best of my kno	owledge, deat	th occurr	ed at the ti	me, date and	l place, an	d due to the	cause(s)	and manner a	as stated.
	ne Hos n 24 h ne Fur oletely	dice		niner: On the basis of examination and manner stated.									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	· //	5	2	9c. Licens	se number	37)		29d. Dat	e signed (Mor	oth, Day, Year)
			-	- //(			9	4530	10		70b	tembe	11,200
6	+1		30 Name and andress of person who	completed cause of death (Ite)	m 23a) (Type,	ATT.	מוטיה	1 Rox	ad A	120	0 \$	el Ar	m. MD2101
ex	Sta	ite.	31. Date filed (Month, Day, Year)	3 Registrar's Sign	ature /	11	,				/		/
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $2\,\overline{0}\,0\,8$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Montgomery n 9:00 AM Sep 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/9/1919 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔯 F 215-09-2870 Director 89 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Exemine rmust be rediffed at once. 10c. City, Town or Location 10d Inside City Limits Funeral Director 1 ☐ Yes 2 ▼No Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4975 Morning Star Drive 21036-1110 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛚 No Completed by Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Snyder Emma Hobson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan H. Montgomery / Son 4975 Morning Star Drive, Dayton, MD 21036-1110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 9/23/2008 Baltimore, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service License 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Encephalopath 5.VUNT /Medical Due to (or as a consequence of): Examiner Brady cardie Sequentially list conditions, if any, bading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box 68760, P.O. Division of Vital Records, illed in by the fi within 24 hours a

Baltimore, Maryland 21215-0036

State Registrar

Shawn 31. Date filed (Month, Day, Year) SEP 1 9 2008

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29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shawn Fyens 5155 Cedar Lone 32. Registrar's Signature

and manner stated.

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D0063653

Columbia, Maryland 21044

29d. Date signed (Month, Day, Year)

September 17,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a, 22, perFH, G883, 9/19/08, WS

State of Maryland? Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 07:00 AM sept 10 2008 Inez Miller /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hospital Baltimore Agnes If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Forei (Month, Day, Year) 9. Sirthplace (State or Forei Country) 16, 1952North Carolina 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🔽 F 56 Director 213-64-5684 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1349 Ramsey Street 21223 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home 10 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Inez Whiteside Henry Miller မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21223 1349 Ramsey Street Baltimore, MD Tonya Miller/daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 09.18.08 Beltsville, MD Chesapeake Crem. 4 □ Donation 3 ₩ Sther (Specify) in State 22. Name and Address of Facility Cata/Stephen D. Lohrman PA 877 Green Patures Dr. Baltimore, MD 21286 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in death) Herer Neutropenic **Physician** 7 days /Medical Due to (or as a consequence of): wound Examiner Klebsiella 85BL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Syphilis Tertiany 5
Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, burial-trans physician a the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed death? this certificate 2140 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or 27. Manner of Cath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 Millural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue, Boddy. St Agnes recraja

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Inez

32. Registrar's Signature

08-069	67
James	Mooney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

nes Mooney	1	State of Maryland / Department of Health and Williams  For State  Certificate of Death	Reg. No. 2008 301
Physicia		egistrar I. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day September 12, 2008  3. Time of Death 0150 hrs
dical Exami	ner	James Alexander Mooney  4b. City, Town, or Local Control Medical Control Contr	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca Lorien Nursing Home Columbia	Howard
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	Under 24Hrs. 8. Date of Birth (MW/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		213.68.8584 1 Mm 2 F 51 Yrs. Months Days F	Hours Min. 06/27/1957 MD
	ļ	Usual Residence of Decedent  10a State 10b County 10c. City, Town or Location	10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Location MD Howard Columbia	1 Yes 2 No
yland a-f sho	횽	10e Street and Number 10f. Zip Code	10g. Citizen of What Country?
he Mar or 28.	Director	6334 Cedar Lane 21044	USA
215-0036  be filed within 72 hours after death with the Maryland nula Hygiene. Hygiene. Hygiene Hygiene Hygiene en, the Medical Examiner must be notified at once.			ic Origin? ( Specify Yes or No- exican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
death or iter	Funeral	1 Never Married 2 Married Armed Forces?  1 Yes 2 No  2 No Specify Cuban, Me	pecify: White
s after iral", miner	ρ	or Dates: 15 December 15 Usual Occupation	(Give kind of work done 16b. Kind of Business/Industry
2 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	
036 ithin 7 ane. rr thar	Completed	Ligilicet	Communications   Mother's Name (First, Middle, Maiden Surname)
21215-0036 Auld be filed within 72 hours after Mental Hygiene, marked other than "natural", to event, the Medical Examiner.		17. Father's Name (First, Middle, Last)	
212' ald be Mental marke	o Be		Margaret Fischer nd Number of Fural Route Number, City or Town, State, Zip Code)
O 73 80 12	-	V. Margaret Mooney 603 S. Ann S	t. Apt. 420 Balto MD 21224 ery, Date 20c. Location - City or Town, State
nore, MD ages 1 and 2 sh ent of Health an nt: If item 27 i		crematory or other place)	
imore Pages 1 ment of H tant; If it		4 Donation 5 Other Specify: Chesapeake Greill	.   09.18.08   Beltsville, MD   Facility CAFA/Stephen D. Lohrmann, P.
Baltimore, permit. Pages 1 at Department of He Important; If ite injury or other to		10 0 0.11. PW1445 14 8717 G	reen Pastures Dr. Balto. MD_
Physician		23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su	ch as cardiac or respiratory arrest, shock, or heart Approximate interval Between Onset and
'Medica	1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Complications of Stab Wound of Neck	Death
tamine		or condition resulting in death)  Due to (or as a consequence of):	· .
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):	
of the state of			
30, te be executed by sician and	dica	UNPENDED AMENDED	23d. Date of delivery
Box 68760, he death certificate be continued to the attending physician	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Month Day Year
ox 6876 eath certificate attending phy	iciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	
D. Boy trithe death by the att	by Physi	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O.	S   S		1 Yes 2 No 3 Probably 4 Unknown
ords, P. w requires th	Completed		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
COF	٧ .		performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Re II: The	or, pag	25. Was case referred to medical 26.Place 0	of Death (Check only one)
Vita ysiclan	To Be	examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5 Residence 6 Other: Scene  v at Work? 28d. Describe how injury occurred
of Ing Ph	uneral	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury 1 Natural 5 Pending Aug 15, 1999 0200 hrs 1 Yes	y at Work? es 2 No  28d. Describe how injury occurred Subject assaulted
Sion Mtendi death.	y the f	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office but	uilding, etc. 28f. Location (Street and Number or Rural Route Number, Cit
Division of Vital Records, tal or Attending Physician: The law requir rs after death.	filled in by the fune	3 Suicide 6 Could not be determined (Specify) Other (Club)	or Town, State) 3700 blk Hudson Street, Baltimore, MD
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician for the former of the certificate has been signed by the attending physician for the former of the certificate has been signed by the attending physician for the former of the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the attending physician for the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has	ely fill		te and place, and due to the cause(s) and manner as stated.
o the Prithin 2 o the 1	completely	Certifying Physician: To the best of my knowledge, death occurred at the thing of the control of	ceath occurred at the time, date and place, and date to the Pour Voor
F 3 F	5 2	29b. Signature and title of certifier  O.C.N	10.0000
		WAD?	
141		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201
	Sta	31 Date filed (Month, Day, Year) 22. Registrar's Signature	
Red			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

riygiche	
Reg. No. 2008	3013
1 D . 11	0 T . (D #

Physician
/Medical
Examiner

TIMOTHY

Year

4c. County of Death

Funeral

Director 28a-f show Director

Funeral

2

23a or Pages 1 and 2 should be filed within 72 hours after death with 3altimore, Maryland 21215-0036

Completed is marked other Be t of Health a injury or other Department of Important: If it any injury or o

**Physician** /Medical Examiner Examiner

physician and the burial-trans be The law requires that the death certificate certificate Hospital or Attending Physician: eral Director: A filled in by the fu

Physician/Medical

Completed by

Be

Certification: To

Medical

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

Box 68760

Ö

σ,

Division of Vital Records,

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEFTEMBER 17 Day OTTE 2008 17:16 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TOHMS HOPKINS BANVIOW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 28, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 XM 2 □ F 1944 North Carolina 215 40 8415 63 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Maryland | Baltimore Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4203 Hollow Spring Lane 21236 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dean William Otte Sybil Burton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4203 Hollow Spring Lane Nottingham, Maryland 21236 Thelma Otte (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 9/20/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. var 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1 ock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC SHOCK disease or condition resulting in death) Due to (or as a consequence of): HOURS PREUMONIA ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury SHTW OW GASTRIC TUBE PERCUTANEOUS that initiated events resulting in death) Last Due to (or as a consequence of)

> STROKE 23c. If yes, outcome of pregnancy
>
> 1 Live birth 2 Fetal death
> 4 Pregnant at time of death
> 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

Year

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 28h Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

performed

1 □ Yes

2 No

29a, Certifier

27. Manner of Death

2 Accident 3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending investigation

6 □ Could not be

determined

29c. License number RES-000

29d. Date signed (Month, Day, Year) SEPTEMBER 17,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHIOUPAKIS, M.D. NESTORAS

State Registrar

31. Date filed (Month, Day, Year) SEP 1 9 2008

4940 EASTERN AVENUE BALTIMORE, MOZIDY 2. Registrar's Signature Grante )

within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z U U & Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17 2008 **Physician** SEPTEMBER 5:30A BROKHA OSTROVSKAYA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE GILCHRIST HOSPICE CARE TOWSON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F Months Days Hours Min. 04/17/1932 UKRAINE Yrs 76 215-27-0312 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprendent institute a once. 1 □Yes 2 No Director BALTIMORE OWINGS MILLS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 104 PLEASANT RIDGE DRIVE, #313 21117 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) **EDUCATION** TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAZUR OSTROVSKY ESFIR ISAAC ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17 RUSH VINE COURT, OWINGS MILLS, MD YELENA MENDELSON / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stat 09/18/2008 OWINGS MILLS, MD HAR SINAI CONG. 5 ☐ Other (Specify) 4 Donati 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign u e Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Astro weak disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner h if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine law requires that the death certificate be executed for use as the burial-transi ag/ that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ned by the a 1 Tyes 2 Min 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate I 2 🗆 No 1 □ Yes 2 🗷 No 1 ☐ Yes Physician; 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? al or Attending P s after death. I Director: After t 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

(Check only one)

29b. Signature and title of certifier

filed (Month, Day,

9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

State Registrar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

S. Md

30

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records.

State Registrar 3110 Gracefield Rd., Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mark Parkhurst, MD

31. Date filed (Month, Day, Yea SEP 1 9 2

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day September 16,2008 William Rickard Parks, II

4b. City, Town, or Location of Death

3. Time of Death

4c. County of Death

9:36 A.M

Physician
/Medica
Examine

4a. Facility Name (If not institution, give street and number)

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Hygiene. other than "natural" or items 23a or 28a-f show other than "natural" or item in ust be notified at ent, the "Modical Examiner in ust be notified at permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any injury or other traumatic event, I'm. Once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be execute and been signed by the attending physician should be detached for use as the burla To the Hospium.
within 24 hours after death.
To the Funeral Director: After this certificate

~moletely filled in by the funeral director, par

Division of Vital Records, P.O. Box 68760,

Baltimore County Apt.1108 Towson 305 E. Joppa Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Months Days Hours 1 AM 2 □ F 454-92-7593 53 April 28,1955 Florida Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 28 No Director Baltimore County Towson Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 United States Apt.1108 305 E. Joppa Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2€ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates: Specify: White þ 3 Widowed 4 XDivorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) n/a Elementary/Secondary (0-12) Towing Service Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Lee Parks Rickard Weston Park, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Emmitsburg, Maryland 21727 Mr. Harris Alan Parks (Brother) 3 Irishtown Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Sept. 2008 20, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr.,P.A.
2325 York Road Timonium,Maryland 21093 21. Signature of Eyneral Service Licen Ae 23a. Raft 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Wellitur Tupe Piances Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day 5 Other (specify) ☐Yes 2☐No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed spercoagulability 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified September 18,2008 D67 434 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Paca, 201 NTIRI Balt more Sherna 31. Date filed (Month, Day, Year) #32. Registrar's Signature State 9 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	State of Ma State Amend 19a, per FH 6883	ryjand/Depf Cen	artment of He tificate of De	alth and M eath	ental Hyg	giene Reg. No. 4	2008	30134
Physici	an	1. Decedent's Name (First, Middle, Last)  James	Purv	1) \$		2. Date of Dea Month	Day	Year 200 &	3. Time of Death  /4:04  M
/Medic Examin	er	4a. Facility Name (If not institution, give street and number)  The Johns Hopkins Hospital		4b. City, Town, or Lo	ocation of Death			ounty of Deat	
Funeral Director			e (In yrs. last birthday) 82 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 2-26-	h y, Year) -1926	9. Birt Cot MAI	hplace (State or Foreign intry) RYLAND
f show	o	Usual Residence of Decedent           10a. State         10b. County           MD •         N/A	10c. City, Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No
with the A 3a or 28a- t be notifie	Il Director	10e. Street and Number 501 E. PRESTON ST. APT 419		10f. Zip-Code 2120	2			n of What Co	untry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Then "natural", or items 23a or 28a-f show ther than "hadical Examiner must be notified at mt, the Medical Examiner.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced  12. Was Decedent Armed Forces?  1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No I	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 🏻 No	panic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		I. Race - Ame Black, White Specify: BI	e, etc.
thin 72 hour e. an "natural" Medical Ex	Completed k	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion rring most of worki	ng		d of Business	
be filed wit tal Hygiene of other that event, the	æ	-120-  17. Father's Name (First, Middle, Last)  WILLIAM PURVIS	<u>_</u>	LABORER	18. Mother's Name	First, Middle	, Maiden S	ER COME Surname)	ANY
nd 2 should Ith and Mer 27 is marke 27 is marke	2	19a. Informant's Name/Relationship (Type. Print) Nance PATRICIA WASH (NIECE)		ing Address (Street ar	nd Number or Run	al Route Numb	er, City or		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mahral Hygien's in the marked other than "natural", or items 23a or 28a-f's any injury or other traumatic event, the Medical Examiner must be notified once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify)  21. Signature of Funeral Service Lice Sec. UNATHEN	20b. Place of Dispo cemetery, creating GARRISON	osition (Name of matory or other place, FOREST VE	TERANS 9	oate -23-200 LLIPS F	20c. Loca 08 OWI UNERA	ation - City or INGS MI AL HOMI	Town, State LLLS, MARYLAN E, P.A.
permi Depar Impo any ir	E 8	23a. Part 1 Inter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not en					RE, MAI	Approximate Interval Between Onset and Death
Physician /Medical Examiner	16	Sequentially list conditions b. 214441	a consequence of):	Ø11411E					
icate be executed physician and street burial-transit	edical Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events  c. Hyptalfa							
aw requires that the death certificate be executed s been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnancy			2	3d. Date of de Month	elivery Day Year
uires that the signed by Id be detact	by	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	en in Part I.				to the cause of death?  Probably 4 Kunknown
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VILA sician: certifica irector,	To Be C	25. Was case referred to medical examiner?  1 🔀 Yes 2 🗌 No Hospital: 1 🔲 Inpat	ient 2 🗆 ER/Outpatie	ent 3 DOA Othe	26. Place of Deat	me 5 Res	idence 6	G ☐ Other (Spe	əcify)
or Attending Physical Colored Physical Colored Physical P	Certification:			M Work		28d. Describe 28f. Location City or To			Rural Route Number,
To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af	ledical Ce	29a. Certifier (check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/or i	ath occurred at the timinvestigation, in my op	ne, date and place pinion, death occu	, and due to th rred at the time	e cause(s) e, date and	and manner d place, and d	as stated. ue to the cause(s)
	Me	29b. Signature and title of certifier		29c. License	66481			e signed (Mor	
3		30. Name and address of person who completed cause of MATTHEW 5. LEVY, 30  31. Date filed (Month, Day, Year)  32. Regist			600	North W	olfe S	t, Baltim	ore, MD, 21287
Si Regis	tate trar	31. Date filed (Month, Day, Year)  SEP 1 8 2008  32. Regist	was It for	parker					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrai Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1307 PM tarru Joseph /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Franklin Square Baltimore HOSPHOL Sex 1 M 2 □ F Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Mpnth, Day, Birthplace (State or Foreign Country) Min. Months Days Hours Manitoba (anada Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21084 2710 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 MYes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Keeve Minnie ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reeves-Janet Sarre 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funcial Chapel-Bel Ai Forest Hill MD 4 ☐ Donation 5 ☐ Other (Specify) 3 Newport DR, Forest HII, NO 21050 21. Signature of Funeral Service Licensee 22. Name and Address of Facility tion Services-Bel Air MOLK Evans Funcial Cha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart (ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) eumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 4 Unknown 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 □ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. May ner of Death 1 V Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760,

**Funeral** 

Director

28a-f show

23a or

injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event

**Physician** /Medical

Examiner

and burial-trar

the attending physician the buria

detached

signed by it

this certificate has been

page,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Division of Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

> State Registrar

Medical

29b. Signature and title of certifier

29c. License number 7855

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who leted cause of death (Item 23a) (Type, Print)

determined

4 ☐ Homicide

(Check only one)

29a. Certifier

Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d, perPHYS., G883,9/19/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year 09/15/2008 3:30 Robert AM Love Ringgold, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlestown Retirement Community Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 05/25/1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1XM 2□F 219-18-2841 83 Maryland Usual Residence of Decedent 10b, Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane Apt. PV 102 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Love Ringgold, Sr. Hilda Rieche 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21228 Mrs. Otillia Ringgold/Spouse 715 Maiden Choice Lane Apt. PV 102 Catonsville MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Sept. 20, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 2008 Glen Burnie, MD 22. Name and Address of Facility
Singleton Funeral & Cremation Services
1 2nd Avenue S.W., Glen Burnie, MD 21061 21. Signature of Funeral Service Lice M00918 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rement disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or ripury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

2008

**Physician** Examiner Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

**Physician** 

/Medical

Examiner

10a State

MD

12

**Funeral** 

**Director** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

ö Department of Important: If any Injury or once.

/Medical

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After this certificate has been signifuneral director, page 2 should be

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Examiner

Physician/Medical

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Completed

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Medical Certification: To

Completed by Funeral Director

Be ၉

within 24 hours a To the Funeral C To the

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

30. Name and address of person

29b. Signature and title of certifier

(Check only



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completed cause of death (Item 23a) (Type, Print)

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MI

08-07040 David Allen Racev

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 30137

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Physici	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Month	Day Year 4700 has
edical Exam	iner	MAIN HOUTH MICOL	4b. City, Town, or Location of Death	mber 14, 2008 1708 nrs 4c. County of Death
		Facility Name (if not institution, give street and number)     6407 Everall Avenue	Baltimore	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	,	of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		UNK 1VM 2 F 50	Yrs. Months Days Hours Min.	13/1951 BALTIMORE, MD
		Usual Residence of Decedent		10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or L	ocation OC	1 V Yes 2 No
Maryland 28a-f show	후	DALIIVIC	10f. Zip Code	10g, Citizen of What Country?
th the Maryland  23a or 28a-f sho notified at once.	Director	10e. Street and Number	21200	11 S A
vith th	a D	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify Yes	
Seath v Jeath v r item	Funeral	1 Never Married 2 Married 1 V yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc	.) White, etc.
after de	by F	3 W Widowed 4 Divorced in res, Give real or Dates:	Yes 2 V No specify:	Specify: WHIE
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. rean 21s anaked other than "natural", or items 23a or 28a-f shi rraumaire event, the Medical Examiner must be notified at once	မ	19a. Informant's Name/Relationship (Type, Print) 19b. M 266		E CITY MD 21234
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 40 or other traumatic event, the Medical		20a Method of Disposition 20b. Place of D	isposition (Name of cemetery, Date	20c. Location - City or Town, State
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Baltimor permit. Pages Department of Important: If	_	21. Signature of Funeral Service Licenspe	22. Name and Address of Facility	00 RD PARKVILLE, MD 21231
		Vilkally C. Coly	EVANS TUNERAL CHAPELT OKE	WHITION SERVICES-HARAVILLE
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Division of Vital Records, pital or Attending Physician: The law requirems after death.  All Directors. After this certificate has been if fitted in his refers these death.	Certification:	3 Suicide 6 X Could not be determined (Specify) house	or T	ation (Street and Number or Rural Route Number, City Town, State)6407 Everall Ave imore, MD
id of a			occurred at the time, date and place, and due to the	ne cause(s) and manner as stated.
To the Hos within 24 h To the Fun	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invariant and manner stated.	estigation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
- F.E.E.S	§ §	29b. Signature and title of certifier	29c. License number  OCME	29d. Date signed (Month, Day, Year)
		Theodore Mr. King JA.	O.C.M.E.	September 15, 2008
		30. Name and address of person who completed caus (of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examin	er 111 Penn Street, Baltimore, MD	21201
	State		East )	
Rea	อเลเ istra	SER 1 0 2000 Manual		

08-07036 Alice Rosier Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lice Rosier	Sta 1- For State Registrar	ate of Maryland /	Certificate of		ivientai Hy	giene Reg.	. No. 20	08 30138
Physician/	1. Decedent's Name (First, Middl	e,Last)				2. Date of Death Month	Day Year	3. Time of Death 1448 hrs
Medical Examiner	WITCH TATE TOO			b. City, Town, or Lo	estion of Dooth	Month E September	14, 2008 4c. County of Dea	
	4a. Facility Name (if not institution Johns Hopkins Hospit			Baltimore			40. Godiniy or Boo	
Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. I For	eian
Director	219-82-9088	1 M 2XF	47 Yrs	Months Days	Hours Mill.	JAN. 1	4, 1961	Country) MD
6	Usual Residence of Decedent  10a. State 10b. County	11	10c. City. Town or Locat	on				10d. Inside City Limits
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5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	5610 TALBOTT P	12. Was Decedent B		s Decedent of Hisp es, specify Cuban,		ecify Yes or No-		nerican Indian, Black,
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Sho sho	19a. Informant's Name/Relations  CHARLOTTE POOL		113	TALBOTT_				21207
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Baltimore, permit. Pages 1 a Department of He Important: If ite	4 Donation 5 / Other S 21. Signature of Fureral Service	Licensee /			of FacilityWESI	EY CHAV	IS, JR. E	NRL. HM.
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transicalical Certification: To Be Completed by Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outcom		etal death 3	Ectopic pregna	incy	23d. Date of deli Month	very Day Year
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Viit To Com	29b. Signature and title of certif	and manner stated.		29c. License	e number	-	29d. Date signed	(Month, Day, Year)
	ocolo-	Seg Mo	)	0.0.1	M.E.		September 1	5, 2008
	30. Name and address of person	n who completed cause of d	leath (Item 23a)				1	
	Tasha Greenberg MI	D. Assistant Medica		Penn Street,	Baltimore, MI	D 21201	<u> </u>	
Stat	31. Date filed (Month, Day, Year	2008 32 Registra	ir's Signature	Mero				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MITICAM Melvin Satchell ZC08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown
If Under 1 Year | If Under 24 Hrs. Baltimore 3530 Resource Drive Apt. 123 Birthplace (State or Foreign Country)
 A Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 229.38.956 82 20/1926 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Kandallstown 1 ☐ Yes 2 No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number USA 3530 Resource Drive. Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 🗙 No Specify: Black Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Dry Cleaners Spotter Othgrade 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (Pirst, Middle, Last) Be aura 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Be ationship (Type. Print) Resource Drive Apt. 332 Randall town Margaret Satchell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD 091 22/08 Garnson Forest 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral SYCS 21. Signature of Funeral Service Licenses Vaigh C & 8728 Liberty Randallstown MD 21133 Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EMPHYSEM **Physician** disease or condition resulting in death) /Medical Due to (or es a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undert, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and, Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ N0 24a. Was an autopsy performed 1□ Yes 2/1 H 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 10 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIME,

State Registrar 31. Date filed (Month, Day,

Year)

SEP 1 9 2008

08-06950 Edward Scott, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 30140

		1- For State Certificate of Death Reg. No. Registrar													
Physicia		1. Decedent's Name (First, Middle,Last)								ate of Death Onth Day Year 1030 hrs					
ledical Exami		l c								Month Day Year September 11, 2008 1030 hrs					
90,00.		EDWARD SCOTT, JR.  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death									unty of Dea	ath			
		5220 York Road	on, give street and n	anibor,		Baltimore									
					1.1.411			er 24Hrs.	9 Date of B	irth/MM/DDA	/// 9 F	Birthplace (State or	$\rightarrow$		
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-	ŀ	Usual Residence of Decedent		13											
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th the Maryland  23a or 28a-f sho	Director	5220 YORK RD APT. #5C 21239								USA					
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15-0036 High within 72 hours after death with the Maryland Highest and "matural", or items 23a or 28a-f she t, the Medical Examiner must be notified at once		15. Decedent's Education (Sp			during mo	s osual occu	life. DO NOT	use retired	d)	100.14110	01 20000	,			
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5-0036 led within 72 Hygiene. other than '	ם	11TH			PLUMB:	ER					L ES	TATE			
od wi	Ö	17. Father's Name (First, Middl	e, Last)				18. Mothe	r's Name (F	First, Middle, Maiden Surname)						
215 e file al H ced c	Be	EDWARD SCOTT,	CD				NANC	Y JAC	OBS						
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica		19a. Informant's Name/Relation	nship (Type, Print )		19b. Mailing	Address (S				umber, City o	r Town, St	ate, Zip Code)			
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MD nd 2 sho alth and m 27 is		NANCY SCOTT/M 20a, Method of Disposition	OTHER	I 20h Pla	ace of Disposi	ition (Name of	cemetery.	1263111	Date						
Baltimore, MD 2121 permit. Pages I and 2 should be li Department of Health and Mental Important: I (Titen 27) is marked injury or other traumatic event,		1 X Burial 2 Crematic	on 3 Removal		ematory or oth	ner place)						or Town, State ONNELL ST.			
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24 } 24 } e Fu	ल	(Gilden string	Physician: To the examiner:On the bas	best of my knowledg	je, death occu	irred at the tim	ie, date and	place, and	aue to tne d t the time d	ause(s) and ate and place	manner as e. and due	to the cause(s)			
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17		Zabiullah Ali, M.D.	Assistant Me	dical Examiner	111 Pei	nn Street,	baiumore	, IVID 212	201						
	State	31. Date filed (Month, Day, Ye		Registrar's Signatu	re A										
	stra	orn 1	9 2008	TRECAS S	3° 135	San Och									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:05 A M Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death BACTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Min 1 ☑ M 2 ☐ F 76 Yrs. 578-36-8687 April 17 1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 142 South Shore Road 21561 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Yes 2 Yes, Give 2 No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney 12 5+ Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Schwartz Shirley Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marlene P. Schwartz 142 South Shore Road, (spouse) Swanton, MD 21561 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 19 Sept. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 2008 21. Signature of Euneral Service Deposee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALREST Due to (or as a consequence of) Due to (or as a consequence of)

23d. Date of delivery

1 ☐ Yes

29d. Date signed (Month, Day, Year)

Day

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

Year

Month

**Physician** /Medical Examiner

Department of Important: If it any injury or o once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

4a.

Examine the attending physician and hed for use as the burial-transit Physician/Medical After this certificate has been signed by the atte funeral director, page 2 should be detached for þ Completed Be Certification: To s after death I Director: /

or Attending Physician: The law requires that the death certificate be executed

death.

within 24 hours a

P.O. Box 68760,

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifie

6 State Registrar

31. Date filed (Month, Day, Year, 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

TREEN

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland	d / Depa	artment of H	lealth and Death	d Mental Hy	giene Reg. No.	008	30142	
	· v		Decedent's Name (First, Middle, I			2. Date of De	Peath 3. Time of Death						
	Physici		RANDOLPH SCOTT						Month AUG.	30	. 200	9:00 A <sup>M</sup>	
	/Medic Examir	_	4a Facility Name (If not institution, g	rive street and number	and number)  4b. City, Town, or Location of Di						County of Dea		
	Funeral		5. Social Security Number 6	. Sex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Year	If Under 24		th	9. B <u>i</u> r	thplace (State or Foreign	
9	Director		216-36-0988	1 <b>⊠</b> M 2□F	67	Yrs.	Months Days	Hours N	in. (Month, Da APRIL 2	y, Year)	941	MD	
			Usual Residence of Decedent		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~								
	n the Maryland r 28a-f show Incliffed at		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits	
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	and 2 salth a n 27 ls		RICARDO WARD			552	26 FREDER	ICK AVE	. CATONS	VILLE	E, MD	21228	
5	f Hee		20a. Method of Disposition			lace of Dispo	osition (Name of matory or other place				•	Town State JELL ST.	
Ę	Page ent o nt: If		1 ☑Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		•		INITY	,	. 1		MORE,		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra <u>once</u> .		21. Signature of Funeral Service Lic		-	-	2. Name and Addres	ss of Facility W	ESLEY CHA	VIS,	JR. FN	IRL. HM.	
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Vital Records, F	es tha	þ	Part II. Other significant conditions	s contributing to death	but not resu	ulting in the u	inderlying cause giv	en in Part I.		obacco us Yes 2□		o the cause of death?	
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ta	sician: Th certificate rector, pag	0	25. Was case referred to medical					26 Place of	1 ☐ Yes  Death (Check only of	2 No	Te:	s 2 No	
Ξ		To B	examiner? 1 ☐ Yes 2 🗙 No	Hospital:	tient 200	ER/Outpatie	nt 3 DOA Oth		ig Home 5 ☐ Resi		□Other (Spe	ecify)	
Division of	g Physical dispersed dispe		27. Manner of Death	28a. Date of In (Month, D	-	28b. Time o		y at	28d. Describe				
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<u>×</u> :	ar de	5	3 Suicide 6 Could no determine	289. Place of I	njury - At ho	me, farm, st	reet, factory, office		28f. Location ( City or To	Street and	Number or F	lural Route Number,	
ā	s atte	Cert	2	building, e	stc. (Specify	′′			City of 10	wii, Siale)			
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes aminer: On the basis and manners	of examinat	wledge, deat tion and/or in	th occurred at the tin evestigation, in my o	ne, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)	
	vithin To th	Me.	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Mon	th, Dey, Year)	
	V122		1 ast	ol, r	ND		7000	0627	35	Sente	mber	11. 2008	
1	2)		30. Name and address of person when Aparna Jo	no completed cause of	death (Item	23a) (Type	Print)	n Bou	levard	Ball	more	e to the cause(s)  th, Day, Year)  7, 11, 2008  7, 11, 21239	
100	Sta Regist		31. Date filed (Month, Day, Year)	32. Regis	trar's Signal	ture	Coals	7 . 50 0	)	. )	.,,,,,,,	)	
022	riegisti	aı	2 L T		-	<i>3</i>	A CONTRACTOR OF THE PROPERTY O						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 13:28 PM Lena Gray Seldomridge sentember 15, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOS DITAL AGNES 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 212-50-63-58 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 2 ☑ No ral", or items 23a or 28a-f sh Expression round be multified Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 2918 Michigan Ave. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, if wholical Experiment once. Black, White, etc. 1 ∏Yes 2₺ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify: Specify: white <u>ک</u> 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everette Lewis Swain China A. Taylor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2918 Michigan Ave.; Baltimore, MD 21227 Mrs. Donna Moyer / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State |Sep.22,2008 Crownsville, MD Maryland Vets. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services; 1 2nd Ave SW; Glem Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) day SERVATIA PNEUMONIA /Medical Due to (or as a consequence of) Examiner Weck ODD Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner month attending physician and for use as the burial-trans SRD Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Year Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MACNUTRITION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CHRONIC has autopsy 1 ☐ Yes 2 1 No Hospital or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi Medical (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) 49005 CAFON 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar SFP19

ELDOM

		Pleas	e Type or P					-		egible.				
	State of Maryland / Department of Health and M  1 - State Registrar Certificate of Death								0000 00111					
	-	Registrar     Decedent's Name (First, Middle,								Reg. No. 2				
Physicia	_								2008	Year	3:30 A M			
/Medic Examin		4a. Facility Name (If not institution,	give street and num		27-27-	4c. County of Death								
LAUIIIII	Ŭ.	Marley Neck				Glen Bı	urnie		Anne Arundel					
Funeral		5. Social Security Number 6	Sex 7	7. Age (In yrs.		If Under 1 Year Months Days	r 1 Year If Under 24 Hrs. 8. Date of Birt Days Hours Min. (Month, Da			th 9. Birthplace (State or Foreign Country)				
Director		218-14-2904	1 M 2 F 85 Yrs. Months Days Hours Min. 9/8/1								MD			
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City Limits			
Mary -fsho ileda	ţō	MD Anne Ai	runda 1	G1	en Bur	nie					1 ☐ Yes 2 No			
n the	Funeral Director	10e. Street and Number	ander		cii bul	10f. Zip Code		1	10g. Citize	en of What Co	untry?			
th with	ョ	7575 East Howard	Rd.			21060	C		U.S	S.A.				
ems a	ner	11. Marital Status	12. Was Deced	dent Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span. Mexican, Puert	pecify Yes or No-	14	1. Race - Ame Black, White				
or It	J.	1 Never Married 2 Marrie	If Yes, Give	e		1 □ Yes 2 No	Specify:	,		Specify: wh				
hours tural"	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Da	tes:	16a Dogg	dent's Usual Occup	ation							
n 72 r "nat edle	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	kind of work done of DO NOT use retired	during most of wor. d)	king	IOD. KING	d of Business/	industry			
withi iene. • thar the M	mo	Elementary/Secondary (0-12)	College (1-	4or 5+)		omemaker	,		(	own Hom	ie			
e filed Il Hyg other	Be C	17. Father's Name (First, Middle, La	ast)		1		18. Mother's Nan	ne (First, Middle,	Maiden S	urname)				
uld be Aenta rked tlc ev	ToB	Henry Weiner					Molly							
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or Items 25a or 28a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or	Town, State, 2	Zip Code)			
and lealth m 27		Susan Ross / fi	riend	1001 -		Wilton Fa								
ges 1 It of H If ite or ot		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3	B □Removal from S	nate i		osition (Name of matory or other place	, 500	Date 19,		ation - City or				
it. Pa rtmen rtant: njury		4 Donation 5 Other (Spe		Ma	-	Vets Cen  2. Name and Addre		I .		nsvill				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	Censee	MAIU							MD 21061			
MEEL.		23a. Part1. Enter the disease, or c	omplications that ca	used the deat	1 11						Approximate			
Physician		shock, or heart failure. List o Immediate Cause (Final	nly one cause on ea	ich line.		And	taria				Interval Between Onset and Death			
/Medical		disease or condition resulting in death)	a. Due to (c	or as a conseq	uence of):	617791	4414							
Examiner		Convention list conditions	b											
₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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be ey ician burial			Due to (c	n as a conseq	derice or).									
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	2	d											
certii nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo						2:	3d. Date of del	iverv			
death e atte d for a	icial	in the past 12 months?  1							Month Day Year					
at the by the	hys	9 □ Unknown	9□Unkno	wn 										
es thai	by F	Part II. Other significant condition	is contributing to dea	ath but not resi	ulting in the u	nderlying cause giv	en in Part I.			co use contribute to the cause of death?				
requii een s	ted	- value	<u> </u>	10011				1 1 1	es 2L	No 3∐ Pi	robably # Unknown			
e law has b	Completed	Devel	رة					24a. Was a autop	ppsy prior to completion of cause of					
n: The									med? 20 No	death? 1 ☐ Yes	2 □ No			
siciar certif	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:			oth Oth	or -	ath (Check only of		_				
Phy er this eral d	-: To	27. Manner of Death	28a. Date o	npatient 2  of Injury	28b. Time o	nt 3 DOA	4 Nursing F	lome 5 Resid			cify)			
nding tth. r: Afte e fune	atior	Natural 5 ☐ Pending 2 ☐ Accident investiga		h, Day Year)	Injury		k? Yes 2 □ No		, ,					
r Atte er dea recto by th	tifica	3 Suicide 6 Could no 4 Homicide determin	ad   Zoe, Flace	of injury - At hong, etc. (Specif	ome, farm, sti	reet, factory, office		28f. Location (S City or Tow		Number or Ri	ural Route Number,			
Ital or rs afte ral Di	Certification:			.9, 0.0. (0,000.				ony or you	,, olaic,					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur		(Check only 2 II Medical E	Physician: To the xaminer: On the ba	isis of examina	wledge, deat ation and/or in	th occurred at the tile	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) a date and	and manner as place, and due	s stated. e to the cause(s)			
thin 2 the orthe	Medical	one) 29b. Signature and title of certifier	and mann	er stated.		29c, Licens	e number		29d Date	signed (Mont	th Day Yearl			
F ≥ F 8							-							
٨.		30. Name and address of person w	ho completed cause	e of death (Item	n 23a) (Tyne		57078		0	71-10	-08 1D 21401			
7		Aditia Char	a M.D	(000			e.#23	Ann	LON	Is m	N 21401			
Sta		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa		- <u>0-</u> <u>/ \</u>	,	- 11111	TU		0,10,			
Registr	ar	SEP 1 9 70	108	ens B	Com	1								
HMH 17 Rev 1/2	001	ULI = V	die .		S. A.									

2. Date of Death 1. Decedent's Name (First, Middle, Last) September Day 16 **Physician** Audrey Tabb Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Crawford Retreat Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** Min. 1 □ M 2 🗓 F Months Days Hours 219-14-0147 Director Oct 30 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, I'm Modical Exercises must be notified at any Injury or other traumatic event, I'm Modical Exercises must be notified at once. 10c. City, Town or Location 10a State 10h County MD Baltimore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2117 Dennison Street 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Y Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ₩ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Completed by Specify Specify: black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

NEVER WORKED 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be John Tabb Annie Carter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 300 W. Preston St., Rm 402, Baltimorre, MD 21201 Paul Lohinski (guardian) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1√ Burial 2 □ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) 9-22-08 Gloucester, VA Berea Cemetery 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Pargespaight 5 enbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 HVO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND THEM 612 per FH 6883 9/19/08 WS Mental Hygiene 2 0

Certificate of Death

Reg. No.

Time of Death

8:15p

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

1 ☐Yes 2 ☐ No

Birthplace (State or Foreign Country)

2008

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

State Registrar

Certification: To

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical

5 Pending investigation

6 ☐ Could not be

UBENOI

1 Yes 2 HNO

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 - State Registrar

32. Registrar's Signature

Date of Injury (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

24 hours after death.

Funeral Director: A

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07079 State of Maryland / Department of Health and Mental Hygiene 2008 30146 Rudolph Allen Turner, Jr. Certificate of Death 1- For State 3. Time of Death 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Year 0155 hrs Physician/ September 16, 2008 <sup>→</sup> Examiner Turner, Jr. Rudolph Allen 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel 517 Cedar Hill Lanc W. Cedar Hill Road Brooklyn If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Country) **Funeral** Min. Days Months Hours 1982 Maryland Director 25 Nov 1 XM 2 F 215-13-2888 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ob. County Yes 2 X No Brooklyn Arundel Anne Maryland hours after death with the Maryland 10g. Citizen of What Country? Director 10f, Zip Code 10e. Street and Number 517 W. Cedar Hill Rd 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-238 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: ö If Yes, Give Year Divorced Widowed 16b. Kind of Business/Industry "natural" 16a. Decedent's Usual Occupation (Give kind of work done ð 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) imore, MD 21215-0036 Pages 1 and 2 should be filed within 7: nent of Health and Mental Hygiene. Hote1 Houseman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie L. Sisco Rudolph A. Turner, Sr. marked event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) If item 27 is n ther traumatic Brooklyn, MD 21225 20c. Location - City or Town, State Cedar Hill Rd 517 W. Bessie L. Turner - mother 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) timore, Burial 2 XCremation 3 Removal from State Baltimore, Maryland Sept. 22 Baltimo
permit. Pages
Department of
Important: I Metro Crematory, Inc. Donation 5 Other Specify 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licenses 3111 Mountain Rd., Pasadena, MD 21122 Approximate Interval Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and 23a. Part I. Enter the disease, or complications that caused th Physician failure. List only one cause on each line. Death **Medical** a. Gunshot Wound of Torso Immediate Cause (Final disease \_xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit x AMENDED 4a,28f per me g883 9-19-08 vt Physician/Medical UNPENDED has been signed by the attending physician 2 should be detached for use as the burial -23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available Completed 24a, Was an Records, prior to completion of cause of autopsy death? performed? 2 No 1 V Yes ✓ Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Nursing Home 5 Residence 6 Other: Scene Division of Vital Be Other<sub>4</sub> Hospital: 1 examiner? ER/Outpatient 3 DOA Inpatient 2 After this ٤ 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Sep 16, 2008 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot Certification 0152 hrs 1 Yes 2 ✔ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natural Pending 28f. Location (Street and Number or Rural Route Number, City or Town, State) **517 W. Cedar Hill Rd** 547 Cedar Hill Lane, Brooklyn, MD Investigation 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. Accident 6 Could not be 3 Suicide (Specify) residence 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 16, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) mes State 2008 SEP LICE WALL

DHMH 17 Rev 1/2001

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 5:40 AM 0 AMEL NEBB /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner andallstown Kaltimore 8. Date of Birth (Month, Day, If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Sex 1 ✓ M 2 ☐ F Months Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinator ust be notified as 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 2 should be filed within 72 hours after death with In and Mental Hygiene.
Is marked other than "natural", or items 23a or: USA Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Blac 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 4 Cau Elementary/Secondary (0-12) 124 cars 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evone. 19b. Mailing Address (Street and Number or Rural Route Number, 3408 C Dr. 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician colon CANCER MEHASHAHIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYDERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 233 twint 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St mo 31. Date filed (Month, Day, #32. Registrar's Signature Year Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 00 A. M Elliott Conway White, Sr. Sakmber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan . 24, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 6. Sex Days Hours 1 2 M 2 □ F 97 217-14-3720 Director 1911 NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examinationst be notified at Director 1 ☐ Yes 2 ₺ No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Phelps Ave. 21060 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No white Specify: 3 ☑ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filled within 72 ho Department of Health and Mentale Hyglene. Important: If item 27 is marked other than "naturny injury or other traumatic event," in Perica. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tug Boat Captain Seafarer's Int'l Union Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Thomas White 으 Katie Gertrude Hodges 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Elliott C. White, Jr./son 409 Phelps Ave.; Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | Sep22,2008 | Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services; 1 2nd Ave SW; Glen Burnie, MD 21061 MO1357 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed 3 Cherma and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the l aftending for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 □ Yes 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number

St

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	,	Certificate of	Death	Reg. I	No.2008	30149
	Dharinin		1. Decedent's Name (First, Middle, La	ist)		SFI	2. Date of Death	Day 6 , 2 (Feight 8	3. Time of Death
	Physicia /Medic	al .	Joseph Walter						
	Examin	er	4a. Facility Name (If not institution, gir Saint Joseph	Wedical Cente	4b. City, Town,	or Location of Death	n	4c. County of Death	imore
ī	Funeral			Sex 7. Age (In yrs. last b	Months   Days		8. Date of Birth (Month, Day, Yea	ar) Coui	place (State or Foreign ntry)
	Director		214-26-0491	78	Yrs.		Dec. 5,	1929 Mai	ryland
	and w	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			1	10d. Inside City Limits
	/aryli	ō		7 loos	and a com				1 □Yes 2 📉 No
	the N	Director	Maryland Harfo.  10e. Street and Number	ra Aber	rdeen 10f. Zip Code		10g.	Citizen of What Cour	ntry?
	3a ol		822 Lynn Lee D	rive	2100	1		USA	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	Hispanic Origin? (Spec ban, Mexican, Puerto F	cify Yes or No-	14. Race - Americ	
2	after or ite		1 ☐ Never Married 2 ☐ Married	1 Mayes 2 □ No	1 □Yes 2 No		. ,	Specify:	_
200	ural",	d b	3 ☐ Widowed 4 🛱 Divorced	Year or Dates: 1947-48	3		166		ite
5	"nati	lete	15. Decedent's E (Specify only highest gr		<ol> <li>Decedent's Usual Occu (Give kind of work done life. DO NOT use retin</li> </ol>	apation e during most of workin ed)	9	. Kind of Business/in	dustry
7	flied within 72 hours after death with the Maryland Hygiene.  Hygiene. Sthan "natural" or items 23a or 28a-f show ent, it et excepted Examinet must be notified at ent.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Mechanic	/		Automotive	3
י כ	filed Hyg other ent, I	Be C	17. Father's Name (First, Middle, Las	t)		18. Mother's Name			
U	ild be fenta rked tlc ev	10 B	Mathew (NMN) We	nner		Tabithia	a (UNK) B	loodsworth	1
a y	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examinat must be notified at once.		19a. Informant's Name/Relationship		9b. Mailing Address (Stree				
Ξ	and 2 salth 27 I		Jan Scott / Com		822 Lynn Le				
ב ב	of He		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 [	20b. Place ceme	e of Disposition (Name of etery, crematory or other pl	ace)	ate 200	c. Location - City or To	own, State
altimor	Pages ment of I ant: If ite		4 □ Donation 5 □ Other (Spec	ify) Hillt	top Service (	Corp. 9/20	0/2008	Towson, M	
20	permit Depart Import any Inj once.		21. Signature of Funeral Service Lice	0 / 1 / N	22. Name and Add	ress of Facility McCo	mas Fune	ral Home,	P.A.
_	20 = 60	_	Muhaen	). Weber (1-5)  nplications that caused the death. D	1317 Coke	sbury Road,	_Abingdo	n, Marylar	nd 21009 Approximate
			shock, or heart failure. List only Immediate Cause (Final	y one cause on each line.		ying, such as cardiac o	respiratory arrest,		Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. CARDIOMYOP					
	Examiner			Due to (or as a consequence CARDIOGENIC	C SHOCK				
Ļ		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or se a consequence	ce of):				
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Ď	an ar rrial-tı		resulting in death) Last	Due to (or as a consequence	ce of):				
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õ	= 5, a	Mec	IF FEMALE:	00- Hive outcome of pregnancy		175		00   Date of dalli	
o n	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal dea  4 ☐ Pregnant at time of death	ath 3 🗆 Ectopic pregna			23d. Date of deliver Month	Day Year
5	the de	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	in Sill Outer (openity)				
7.	that the		Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause g	given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
5 S	w requires that the death cer been signed by the attendir should be detached for use	d by					1 □ Yes	2 ☐ No 3 ☐ Pro	bably 4 Unknown
ပ	law rec as bee 2 shou	Completed					24a. Was an		topsy findings available ompletion of cause of
Ä	The la ate ha	шo					autopsy performed 1 □ Yes 2 D	d? death? Mo 1⊡Yes	
	fan: '	a	25. Was case referred to medical examiner?			26. Place of Death			
OT <	Physician: rthis certific ral director,	To B	examinery 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA		me 5 🗆 Residenc	e 6 □Other (Spec	ify)
0	ng Pl	::	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	b. Time of 28c. In Injury W		28d. Describe how	injury occurred	
20	tendi leath. tor: / the fu	cati	2 Accident investigati 3 Suicide 6 Could not	L.		□Yes 2□No	Opt Location (Street	at and Number of Pu	ral Pauta Number
DIVISION	al or Attending F s after death. I Director: After d in by the funera	Certification:	4 ☐ Homicide determine		, іанн, энеец іастогу, опіс		City or Town, S	et and Number or Ru State)	ar riodie Namber,
_	e Hospital of 24 hours at e Funeral D		29a. Certifier 1 CertifyIng	Physician: To the best of my knowle	edge, death occurred at the	e time, date and place,	and due to the cau	se(s) and manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to completely filled in by the funeral director, page 2 to the funeral director.	edical	(Check only 2 Medical Ex	aminer: On the basis of examination and manner stated.	n and/or investigation, in m	y opinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of pertifier	1		ense number	290	Date signed (Month	, Day, Year)
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10+1 State Registrar

KHOSROW TABASSI.
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D. 32. Registrar's Signature

7601 OSLER DRIVE

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07089 State of Maryland / Department of Health and Mental Hygiene Fetus Wright Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Physician/ 2129 hrs September 16, 2008 phavon Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center (MM/DD/YYYY) 9. Birthplace (State or of Birth If Under 1 Year If Under 24Hrs. 3. Date. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Country) Director 2 Yrs Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 1 Yes 2 No MD urnie or 28a-f show must be notified at once Director 10g. Citizen of What Country 10f. Zip Code 10e Street and Numbe 21061 or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status White, etc Armed Forces? 1 Never Married Yes 1 Yes 2 No specify:

16a. Decedent's Usual Occupation (Give kind of work done If Yes. Give Year 4 Divorced Health and Mental Hygiene. item 27 is marked other than "natural", traumatic event, the Medical Examiner þ 15. Decedent's Education (Specify only highest grade completed) 72 hours during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Pages 1 and 2 should be filed within and Open of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surna 17. Father's Name (First, Middle, Last) LINK å (Street and Number or Rural Route Number, own, State, Zip Code) 19a. Informant's Name/Relationship (Type, Prin en Burnie 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place) 2 Cremation 3 Removal from State Donation 5 Other Specify: nature of Funeral Service Licens D Balto Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Physician /Medical Death Prematurity Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Acute chorionitis & congenital pneumonia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last X AMENDED PI line a-b, 27, per ME g886 12/9/08 TT signed by the attending physician and be detached for use as the burial - tran Physician/Medical X UNPENDED the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year Ectopic pregnancy Month Day 23b Was decedent pregnant in the Live birth Fetal death Pregnant at time of death 5 Other (Specify) Sep 16, 2008 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown <u>ج</u> Completed 24b. Were autopsy findings available certificate has been s rector, page 2 should 24a. Was an prior to completion of cause of autopsy death? performed? Yes 2 ~ Yes No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other examiner? Other Hospital: Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 After this 1 Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending 24 hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3 Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Brekrie

111 Penn Street, Baltimore, MD 21201

MID

32f Registrar's Signature

BARR.

30. Name and address of person who completed cause of death (Item 23a)

2008

Ling Li, MD

31. Date filed (Month, Day Year)

Assistant Medical Examiner

O.C.M.E.

State

Registra

September 17, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Williams 10:14A SEPTEMBER 16 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE SINAI HOSPITAL OF BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 09/21/1967 1 □ M 2 🕱 F PA 40 213-72-1202 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventher must be evillated anone. 10a State 1 □Yes 2 🕅 No Funeral Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA 5 COBBLESTONE COURT, APT. T-3 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 XINo Specify: Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DENTAL DENTAL HYGIENIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GOLDENBERG MARILYN ALBERT SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) COBBLESTONE COURT, APT. T-3, BALTIMORE, MD MICHAEL ALBERT / BROTHER 20b. Place of Disposition (Name of cemetery, grematory of pitter place)
BENEFICIAL CIRCLE 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 09/18/2008 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral S SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner rington Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the 23d, Date of delivery 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 ☐ impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28b. Time of 28d. Describe how injury occurred 27. Mann of Death 28c. Injury at Work? 28a. Date of injury 5 Pending investigation (Month, Day, Year) 1 atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ristinge MD todrow 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per FH 8883 9/25/08 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 05 A M **Physician** 12 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rosedale Ballimore FRANKLIN Center Square HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Scounds (Month, Day, Year) | 93| 5. Social Security 8umber 2/3-38-7223 6. Sex 1 M 2 □ F 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Modical Examinar must be notified at once. Baltimore 1**X**iYes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 115.4 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Des 2 Do Ir Yes, Give 3 G, 1952 Year or Dates; Au G 27,1954 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ge (1-4or 5+) Elementary/Secondary (0-12) STRUCTION UNStruction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21206 72 Kadecke White 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sept 24,2008 Dwings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 23a. Patt: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final • Physician Preumocystis
Due to (or as a conse fience of): Preymonia 3 weeks disease or condition resulting in death) /Medical **Examiner** undo (or as a consequence of): unknown Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate tetely filled in by the funeral director, page 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63054 ETTEMBER 15, 2008 X ess of person who completed cause of death (Item 23a) (Type, Print) SOUARE DRIVE, BALTIMORE, MD حص NIND CINA, MD, 21237 FRANKLIN 31. Date filed (Month, Day, Year) SEP 1 8 2008 32. Registrar's Signature State SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month John Albert Ager 10:40 2008 Sept 3, 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Sacred Heart Home Nursing Center Hyattsville if Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Hours Months 1 ☑ M 2 □ F Days 578-30-2320 81 1926 Washington, 23, Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5805 Queens Chapel Road 20782 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. orces: 1 ⊠Yes 2 ☐ N If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🎦 No Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Civil Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) un-avail. John Joseph Ager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bristow, VA 20136 Sue Callahan / Partner 9531 Moonen Bay Lane, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 09/07/2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Myocardial Infarction 10 Months disease or condition resulting in death) Due to (or as a consequence of): Respiratory Failure Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ! 23e. Did tobacco use contribute to the cause of death? Osteoporosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Failure to Thrive 24a. Was an 1 ☐ Yes 2 🗓 No 25. Was case referred to medica

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show

Director

Funeral

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Physician/Medical

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Certification: To

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 and 2 should be Health and Mental

Pages 1

27 ls

If item 2 or other

Department of Important; If any injury or once,

law requires that the death certificate be executed sician and burial-trans physician the attending p sign be been page 2 Physician: The certificate director, After thi funeral Hospital or Attending after death Director: /

Box 68760,

P.0.

Division of Vital Records,

Lo. Trab babb folding to intodical	26. Flace of Death (Check only one)									
examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)								
27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not to determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)								

09/05/2008

(Check only 29b. Signature and title of certifier

29a, Certifier

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Much 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman Rekha Tuli, 3503 Perry, Suite B, Mt. Rainier, MD 20712

Registrar

filled in 24 hours a Funeral L

npletely

To the within 2
To the I

31. Date filed (Month, Day, Year) SEP 0 8 2008

32. Registrar's Signature

			1 - State Amend Item 25 per me, g	and / Der 884,10/	partment of F 24/08dhb.2 Frtfficate of 1	Beath Beath	ептат пу	Reg. No	8009	301	55
	Physici	an	1. Decedent's Name (First, Middle, Last) Gretchen Lynch Anthony				2. Date of De Month Sept.	Da	y Year 2008	3. Time of 9:09	f Death P M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	верс.		. County of Death		
	Examin	er	Suburban Hospital Bethesda Montgomery							-	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)		nplace (State ountry)	
	Director		Usual Residence of Decedent				03/19/	1920	west	: Virgi	.nia
	yland how			. City, Town or I						10d. Inside C	•
	e Mar 3a-f s	cto	MD Montgomery Be	ethesda							2 <b>₹</b> No
	DESITIMOTE, IMBITYIBING ZIZID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Midfoll Event in mist be notified at once.	Funeral Director	10e. Street and Number 6901 Whittier Blvd.		10f. Zip Code 20817			_	tizen of What Cou		
	ems:	ner	11. Marital Status 12. Was Decedent Ever i Armed Forces?	n U.S. 13	B. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No Rican, etc.)	0-	14. Race - Amei Black, White		
Š	USO urs after all; or its	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify: White			
	72 ho 72 ho natur	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					(ind of Business/I	ndustry	
3	Ban ifthin	햩	Elementary/Secondary (0-12) College (1-4or 5+)								
č	Iled w Hygie ther ti	ပ္ပ	17. Father's Name (First, Middle, Last)	Pia	no Teacher	18. Mother's Name	(First, Middle		Busines	3S	
	and d be f ental   ced of c eve	o Be	Laurence R. Lynch			Gretch	en M.	Spin	dler		
	Should Me Me In Y	ဍ	Laurence R. Lynch  Gretchen M. Spindle:  9a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town							ip Code)	
	MS nd 2 ( alth a 27 is		Robert Anthony / Son	690	l Whittier	Blvd. Be	thesda	, MD	20817		
	item		20a. Method of Disposition	b. Place of Dis	position (Name of ematory or other place	ce)	ate	20c. L	ocation - City or	Γown, State	
	Page Page Int: If	r	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Nationa	1 Cremator	v Sept.	5,08	Fa1	ls Churc	ch, VA	
Z	baltimore, Maryland ZIZI3-0035 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, in "indical Even once.		21. Signature of Funeral Service Licensee		22. Name and Addre						5
0			23a. Part 1. Enter the disclasse, or complications that is used the conshock, or heart fail re. List only one cause in each line.	death. Do not e	enter the mode of dyir	ng, such as cardiac c	or respiratory a	arrest,		Approxima Interval Be	ite etween
0	Physician		Immediate Course (Final	cardial	- U I					Onset and	Death
2	/Medical		resulting in death)  Due to (or as a con-			DONNE DONNE	.0	£	1		****
CB	Examiner	_	Sequentially list conditions, b.				- Mul	MER	NVO I		
3	ted	edical Examiner	Sequentially list conditions, if any, reading to finine date cause. Enter Underlying Cause (Disease or injury that initiated events	sequence ou		5 N8 (	BY MEDICAL EX	The MANNIER	Pr .		
8	execu and	xan	that initiated events c	sequence of):	Lan	WA DA APPROVED	11.40	ye.			
01 108	b&/bU, tificate be ex g physician as as the burial	cal	d.		J CER	UEICHINA DONNE	loc.				
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0	I HECONGS, P.O. BOX b8/b0,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Completed by Physician/IV	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 X No 9 □ Unknown  23c. If yes, outcome of properties in the past 12 months?  4 □ Pregnant at time 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _				23d. Date of del Month		Year
_) (	that the dended by the detached	P	Part II. Other significant conditions contributing to death but not	t resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of	death?
_	rdS, Fuires that a signed!	d by	Foly, Phabdomyolysis, Al	ef, Ho	yfinatremi	2	1 🗆	Yes 2	2 □ No 3 □ Pr	obably 4 🔼	Unknown
(P)	Kecord  le law require has been si ge 2 should b	lete	Myeakalemia Acidesis Va	in some of	rset infec	tim	24a. Was		24b. Were au	itopsy findings	s available
	He(	ᄩ	A	10001	·	-11071	auto perf 1 □ Yes	opsy formed? 2 N	death?	completion of 2 □ No	cause of
7	lan: ]	Be	25. Was case referred to medical	- Choop a		26. Place of Death			0 1 1 1 1 6 3	2 🗆 140	
W:	T V  nysici nis ce direc		examiner?  1 A Yes 2 A Hospital: 1 Inpatient	2 ER/Outpat	tient 3 DOA Oth	ner: 4  Nursing Ho	me 5□Res	sidence	6 ☐ Other (Spe	cify)	
0	ng Pł	Ë	27. Manner of Death 1 XNatural 5 Pending 28a. Date of Injury (Month, Day, Yea	28b. Time Injur	y   Wor		28d. Describe	how inju	ury occurred		
9.	//SION OT VITAI Attending Physician: T reath. ector: Atter this certificat by the funeral director, pa	cati	2 Accident investigation			]Yes 2□No	006	(044			
-	DIVI lor At after d Direct	ertifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S <sub>i</sub>	ecify)	street, factory, office		City or To	(Street a own, Stai	ind Number or Ri te)	irai Houte Nui	mber,
nthonu	DIVISION OT VITAL HO To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	Medical Certification: To	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my one)  Medical Examiner: On the basis of exa and manner stated.	y knowledge, de mination and/o	eath occurred at the t	ime, date and place, opinion, death occur	and due to th red at the time	e cause( e, date ar	(s) and manner and place, and due	s stated. to the cause	(s)
干	To the within To the Compl	Me	29b. Signature and title of certifier		29c. Licens				ate signed (Mont	h, Day, Year)	
			H. Ald. MD		D	0062167		9	1/2/08		
A			30. Name and address of person who completed cause of death	(Item 23a) (Typ	e, Print)	7570					
			Hossein Akhomdi MD 8600 01d (		own Road B	Bethesda M	D 208	14			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's S		Contes						
	negist	التم	10000	1 10	The state of the s						

State

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, D

DHMH 17 Rev 1/2001 OCME 2006

Registrar

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 3, 2008

's Signature

and manner stated

Assistant Medical Examiner

OCME

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07014 State of Maryland / Department of Health and Mental Hygiene Gary Robert Bass Certificate of Death 1- For State 2. Date of Death Registrar Month Day Year September 13, 2008 1. Decedent's Name (First, Middle,Last) 2107 hrs Physician/ Medical Examiner Gary Robert Bass 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Min Days Months September 12,1980 Director 219-96-3368 28 Yrs 1X M 2 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 1 Yes 2X No -f show Washington Hancock once 10g. Citizen of What Country? 10f. Zip Coda s 23a or 28a-f 10e. Street and Number 14617 White Oak Ridge 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral White, etc. or items must be Armed Forces? Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
Sant: If item 27 is marked other than "natural", or item or other traumatic event, the Medical Examiner must be other traumatic 1 X Never Married Married 2 1 X Yes Specify: White Yes 2 X No specify: If Yes, Give Year Divorced 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ğ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Complet Truck Accessories Sales Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth A. Henderson 2121 Be Henry E. Bass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ဥ 14617 White Oak Ridge Hancock, MD 21750 B Ruth A. Bass/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, permit, Pages I and Department of Heal Important: If item injury or other trains 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 09/19/2008 Big Cove Tannery,PA Damascus Cemetery 109/19/2000 1215 - 122. Name and Address of Facility 141 West Main Street Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Grove Funeral Home P.A. Hancock, MD 21750. Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Death failure. List only one cause on each line. Medical a. Pneumonia Immediate Cause (Final disease ∡aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit AMENDED 23a, PII, 2/, perME, göö4 10/29/05 11 The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician for use as the burial -23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760, IF FEMALE: Year Dav Month Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown ned by the atte detached for u 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. Yes 2 No 3 Probably 4 V Unknown þ Methadone use 24b. Were autopsy findings available 24a. Was an Completed ricate has been s. page 2 should b Records, prior to completion of cause of autopsy death? performed? 2 No 1 V Yes Yes 2 No After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Residence 6 Other: Other<sub>4</sub> Nursing Home 5 examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day,Year) 27. Manner of Death Yes 2 No Certification: 1 X Natural Pending Division after death. 28f. Location (Street and Number or Rural Route Number, City the Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc in by within 24 hours after d To the Funeral Direct completely filled in by or Town, State) Could not be 3 Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Checone) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 14, 2008

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

OCME

Assistant Medical Examiner

32. Registrar's Signature

MARIAR.

30. Name and address of person who completed cause of death (Item 23)

2008

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

ORIGINAL

TO ALL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DUNE

		1	- 701	Department of Health and M Certificate of Death		giene leg. N2 008 30158
			Decedent's Name (First, Middle, Last)		2. Date of Dea	th 3. Time of Death
	Physicia		Carl Wayne Burns, II		Month August	28 2008 7:11 a. <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August	4c. County of Death
1	Examin	er	42 Virginia Avenue	Bloomington		Garrett
			5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Foreign
	Funeral Director		ATT A COLO	Yrs. Months Days Hours Min.	(Month, Day Oct. 31	Country) Cumberland, MD
			Usual Residence of Decedent			
	yland Now		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Mar 1-f st	to	WV Mineral Key	ser		1 X Yes 2 ☐ No
	r 284	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	h witi		441 N. Main Street	26726		USA
	deati	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	hin 72 hours after death with the Maryland 9. an "natural", or Items 23a or 28a-f show Medical Examiline must be motified at	by Fui	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: White
Maryland 21215-0036	2 hou		15. Decedent's Education 16a.	Decedent's Usual Occupation		16b. Kind of Business/Industry
75	in 72	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	aing	
212	E the Ki	E O	0	Never Employed		N/A
b	be filed ntal Hygie od other event, ti	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Sumame)
<u>a</u>	should be and Mental s marked o umatic eve	0	Carl Wayne Burns	Tamica	Ann Bak	ter
ary	2 should and N is maintenant		19a. Informant's Name/Relationship (Type, Print) 19b.	. Mailing Address (Street and Number or Rui	al Route Numbe	r, City or Town, State, Zip Code)
	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Tamica A. Fertig/Mother	441 N. Main Street	Keyser	WV 26726
ē,	s 1 a of Hea item othe		20a. Method of Disposition 20b. Place of	ar aromatons or other place)	Date	20c. Location - City or Town, State
E	Pages nent of int: If it	li	1 🔀 Burial 2 □ Cremation 3 □ Removal from State  `4 □ Donation 5 □ Other (Specify)  Potoma	c Memorial Gardens	Sept. 1 2008	Kevser, WV
Baltimore,	구두판구	1	21. Signature of Euneral Service Lines si	22. Name and Address of Facility		neral Home
ä	permit Depar Impor any ir		1 Touan ordell	85 S. Main Stree	t Keys	ser, WV 26726
	Pnysician /Medical Examiner	ier	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter of Jary in Cause (Disease or injury)	rowning of):		Onset and Death
68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C	of):	- Die	Me Me Me Con France
O. Box	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		obacco use contribute to the cause of death?  Ves 2X No 3 Probably 4 Unknown
al Records,	(0 1	Completed			1 Yes	prior to completion of cause of death?  2 No 1 Yes 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Dea		Care iver'
of	this al di	2	1 X Yes 2 No 1 Inpatient 2 EN/OU	apatient 3 DOA 4 Nuising H	-	dence 6 X Other (Specify Residence
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Division	r Attending er death. rector: After by the fune	icat	3 Suicide 6 Could not be as Blace of Injury At home to		SWITHINITE	treet and Number or Rural Route Number
<u>≥</u>	in the	ırtif	4 Homicide determined building, etc. (Specify)	ini, siteet, factory, office	City or Tov	<sup>vn, State)</sup> Rockland Farm Road
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical Ce	Phome  29a. Certifier (Check only (Check only 22 Medicel Examiner: On the basis of examination are			
	the hin 24 the F	Medi	one) and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
	To To		29b. Signature and fittle of forther			
				16425		Sept. 2, 2008
			30. Name and address of person who completed cause of death (Item 23a)			
			Bilal Itani, M.D. 233 S. Mine	ral Street Keyser,	WV 26	5726
•	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 9 2008	polis		

			For State Registrar	State of	Marylan		artment rtificate			nd Mental H	ygiene Reg. No. 4	2008	301	159
			Decedent's Name (First, Middle	, Last)						2. Date of D		Year	3. Time of D	Death
35	Physici: /Medic		Clarence Frank	din Brown						Septem			9:05	ΑM
an his	Examin		4a. Facility Name (If not institution	-	per)		,		Location of I	Death		County of Death	_	
1			Kline Hospice		0	f 4 f- 1-46 - d 1	Mou:			Hrs   9 Data of B		rederic		Foreign
	Funeral Director		5. Social Security Number 217–12–1501	6. Sex 7. 1 1 M 2 □ F	Age (In yrs. 84	Yrs.	Months	Days		Min. Jan. 1	2 19	24 Coul	olace (State or ntry) Maryl	and
			Usual Residence of Decedent							Dear 1	2, 17.			
	ryłan ihow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	1 ☐ Yes	
	Ba-f s	Director	J	lerick	M	onrovi					1.0 000	(11111 - 1 - 0 - 1		2 <u>A</u> JN0
	vith th	Pir	10e. Street and Number	hand Dand			10f. Zip	<sup>Code</sup> 1770	,			en of What Cour ited St	•	
	sath v	Funeral	12505 Fingerbo	12. Was Deced	ent Ever in II	S 13				n? (Specify Yes or N		4. Race - Americ		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Examinar round for notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed Force	es? No		if Yes, spec 1 □ Yes 2	ify Cuba	n, Mexican, F Specify:	Puerto Rican, etc.)		Black, White, Specify: Whi	etc.	
-0-	2 hou latura	ted	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usua	Occupa	ation	f working	16b. Kin	d of Business/In	dustry	
215	thin 7 ne. nan "n	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)				during most o 1)		C		D-ded a	_
12	ed wi		1.2			In	vento	ry M	lanager	Name (First, Midd		ercial	Dairies	5
and	be fill	B	17. Father's Name (First, Middle, I Oscar Brown	Last)						le Stine	ie, maideri s	urname)		
Z	should be tnd Mentai s marked c umatic eve	은	19a. Informant's Name/Relationsh	nin (Tima Print)		10h Maili	na Address	(Street :		or Rural Route Nun	nher City or	Town State Zi	n Code)	
Ma	d 2 sl Ith an 27 is r traur		C. Robert Brown				3	1		, Mt. Aiı				
	f Hea f Hea item 2		20a. Method of Disposition		20b. F	Place of Dispo				ptember		ation - City or To		
m 0	Pages lent o nt: If i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		are i	oviden				6, 2008	Mt.	Airy, Ma	arvland	1
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai		21. Signature of Funeral Service		MO1	Ke	2. Name an	d Addres	ss of Facility	PA Funer	al Hor	ne		
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	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on eac	ch line.	10-4	2- /		1:0.11	and.	2		Onset and D	)eath
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	ф <u>н</u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a conseq	uence of):	1	//						
OU.	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
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E B	The cate h	Son								pe 1 □ Yes	rformed?	death? 1 ☐ Yes		
/ita	cian: ertific	Be (	25. Was case referred to medical examiner?	11				045		f Death (Check onl	y one)		14051	DICE
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u C	Jing I	ion	27. Manner of Death  1 Natural 5 □ Pendin		, Day, Year)	Injury	M 2	8c. Injur Worl	yat k?  Yes 2.∐No		e now injury	occurred		
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οįς	after after Direction	Certification: To	4 ☐ Homicide determ	ined building	g, etc. (Speci	ome, farm, st	,			City or 1	Town, State)			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as			g Physician: To the bearings:										(3
	the Hin 24 the Figure 14 the Fi	Medical	one)	and manne							_			
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			Man /	courses,	MD	)		) 3	)/1	16	Scpz	tember t MD	-15, X	100
	20		30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type,	Print) 14	F.		In a	V.	+ Mr	) 2/7	1091
	Sta	te	31. Date filed (Month, Day, Year)	32 <b>4</b> Re	gistrar's Sign	ature		218	cel,	IVEGE	1161		ALC:	V/_
	Regist		SEP 1 9	2008	Berton A	× A	w							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 10:25 P<sup>M</sup> Blake 2008 September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charlotte Hall Veteran's Home Saint Mary's Charlotte Hall Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 x M 2 □ F 87 250-14-4941 August 2, 1921 South Carolina Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Motical Experience must be notified at 1 X Yes 2 □ No St. Mary's Charlotte Hall Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20622 29449 Charlotte Hall Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ð 3 Widowed 4 □ Divorced American Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Offset Printer Government 3 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Smith Frank Blake ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15240 Rolling Meadows Road Upper Marlboro, MD 20772 Carolyn V. Hodge - Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 jo 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. Maryland Vet's Cemt. Sept 12, 2008 Cheltenham, MD ☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Si ature of Funeral Service A 4001 Benning Road, NE Washington, DC 20019 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DEBILIT **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner EMENTI Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and the burial-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s performed? Yes 2 No certificate | 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifica completely filled in by the funeral director, p 25. Was case referred per edical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MD 00 8

31. Date filed (Month, Day, Year) State SEP 0 8 Registrar

RAO KODA 32. Registrar's Si

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EENA

2008

20622

29449 Charlotte Hall Rd Charlotte Hall, MD

Joseph Lawrence		utler 1- For State	State of Maryl				d Mental Hy	ygiene	0.5	
		Registrar  1. Decedent's Name (First, N	Eddin Look	Ce	ertificate of	Death		Re 2. Date of Deatl	g. No. 2	148 301-6
Physicia Medical Examir	111/		_					Month September	Day Year	1455 hrs
/		Joseph  4a. Facility Name (if not inst	Lawres	nce		Sutler 4b. City, Town, or	Location of Death		4c. County of I	Death
		40775 King Drive	, allow, give all det alle in			Mechanicsville			St. Mary's	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	r If Under 24Hrs.	. 8. Date of Birt	h(MM/DD/YYYY)	Birthplace (State or
Director		216-40-5135	1X M 2 F	66	Yrs	Months Days	Hours Min.	Feb.26		oreign Country)Maryland
	ł	Usual Residence of Decede		00				1100.20	, 1742	Haryrand
any		10a. State 10b. Cou	inty	10c. Cit	ty, Town or Locat	ion				10d. Inside City Limits
nd show	٦	Maryland S	t. Mary's	1	Mechanio	sville				1 Yes 2 X No
Aaryla 28a-f	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?
the As or		40775 King	Drive			20659			USA	
with ms 2.3	Funeral	11. Marital Status		cedent Ever in			panic Origin? (Sp , Mexican, Puerto		14. Race - A White, 6	American Indian, Black,
deatl or ite	핊	1 Never Married 2 X	1 Yes	2 X No	-			. 20011, 0101,		
s after ral",	ğ	3 Widowed 4	Divorced If Yes, Give Ye or Dates:			Α	specify:		Specify:	Black
hours natu	fed	15. Decedent's Education Elementary/Secondary (0		1-4 or 5+)			tion (Give kind of v . DO NOT use reti		16b. Kind of Busir	ness/industry
36 iin 72 han '	ble	9	-12) College	1~4 01 5+)	Lab	orer			Const	ruction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Completed	17. Father's Name (First, Mi	ddle, Last)				18.Mother's Name	(First, Middle, N	Maiden Surname)	
215 e file tal Hy ked o	Be (	E1i	Jennifer				Agnes	Luci	110 1	Rutler
21. Ould b I Men in arrice eve	10	19a. Informant's Name/Rela	tionship (Type, Print )		19b. Mailin	g Address (Stree		Rural Route Num	ber, City or Town,	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.		Rose M. Butl	er/Spouse		40775	King Dr	ive. Mec	hanicsv	ille MD 20c. Location - C	20659
Fe, I and Fred Fred Fitten		20a. Method of Disposition 1 X Burial 2 Crem	_		<ul> <li>Place of Disposition</li> <li>crematory or ot</li> </ul>		metery,	Date	20c. Location - C	ity or Town, State
Baltimore, pernit. Pages I ai Department of He Important: If ite		4 Donation 5 Oth	er Soecify		Oueen of	Peace				sville, MD
Baltimo permit. Page Department o Important: injury or out		21 mature of Funeral Se	ruce Liernsee	M00052	22.1	Name and Address	of Facility Bri	.nsfield	Funeral	Home, P.A.
<b>m</b> & ă <b>s</b> .s	9	dun///	Edward	N. Bri	nsfiel20	955 Holl	.vwood Ro	ad, Leo	nardtown	MD 20650
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ted 1 ansit	Exa	(Disease or injury that initia events resulting in death) L	led Bush (	a consequence	e of):					
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of Vital Records, ng Physician: The law require After this certificate has been si uneral director, page 2 should b	To	1 ✓ Yes 2 No		Inpatient 2	ER/Outpatien				Residence 6 🗸	
n of ding Ph		27. Manner of Death  1 ✓ Natural 5	(Mor	e of Injury th, Day,Year)	28b. Time of	· ·   _ ·	ry at Work? Yes 2 No	28d. Describe	how injury occurred	
Sion Attend r death. ector: by the	ati	2 Accident	Pending Investigation					000 1	Ol	as Donal Davids Northern City
Division spital or Attendit to the function of the function of filled in by the function:	Certification:		Could not be determined (Specification)		t nome, tarm, stre	eet, factory, office t	building, etc.	or Town, S		or Rural Route Number, City
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Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only	ng Physician: To the be Examiner: On the basis	of examination						
To To con	Mec	29b. Signature and title of c	and manner ertifier	stated.		29c. Licens	se number	-	29d. Date signed	(Month, Day, Year)
		hig h	om ' r			O.C.	M.E.		September 4	4, 2008
		30, Name and address of po				. D	LID C.O.		<u> </u>	
Pr	ate	**	sistant Medical Example (ear) 32.1	aminer 1' Registrar's Sign		et, Baltimore,	MD 21201			
Regist		31. Septed (Month, Day.)	8	KA	Lade					

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** August 29, 2008 1:35 pM Bruna Maria Carbonaro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Olney Montgomery Montgomery General Hospital 8. Date of Birth (Month, Day, July 14, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday **Funeral** <sup>Year)</sup> 1948 Months Days Hours Min 1 M 2 F Italy 60 Director 577-66-7359 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, It a Medical Exp. all at a unatical collection 1 Yes 2 No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20905 USA 402 Hilton Head Court Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Specialist Own Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 27 is marked of Marianna Giliotti Riccardo Gulio Giliotti ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 402 Hilton Head Court, Silver Spring, MD 20905 Adrian J. Carbonaro/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) entombmen t Sept. 3, d Gate of Heaven Cemetery 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final pancreatic Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed and y physician an is the burial-tr Due to (or as a consequence of): O. Box 68760 Physician/Medical as the the attending phase for use as t IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Hinknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ninpatient မ 2 ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day, Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. I Director: / d in by the fi 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide thin 24 hours a Hospital t 🕏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ဂ္

State Registrar 31. Date filed (Month, Day, Year) SEP -

30

DHMH 17 Rev 1/2001

FINCE PHILIP DR. OLNEY MD 20832

of person who completed cause of death (Item 27a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 5, 2008 4:47 A **Physician** Elizabeth Cardamone /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Leonardtown St. Mary's Nursing Center If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Year) August 18, 1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 92 Pennsylvania 1 M 2KK 187-01-4439 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2XXNo Forestville Director Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Item 27 Is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be a 20747 USA 6613 Nyack Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XXNo Specify. Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othany Injury or other traumatic event Be Chiodo Sarah Ralph Cardamone ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29350 Rolling Acres Lane Mechanicsville, Maryland Sara Neill Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Calvary Cemetery 09/09/2008 Punxsutawaney, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signatule of Fundial Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland Raph. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lin x Approximate Interval Between Ogset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or all Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the aid 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 10 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical after death.

Director: After this certific

in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA £ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours af e Funeral D detely filled ii 1 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Fun completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifier

31. Date filed (Month) Day, Year) State 2008 8 Registrar

24035 Three/Notch Rd. #640 Hollywood, Maryland 20636 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

James Patrick Jarboe

08-06904 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 30165 State of Maryland / Department of Health and Mental Hygiene Andre Bramon Crawford Certificate of Death Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day September 9, 2008 1440 hrs Medical Examiner Andre B. Crawford 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's 8434 Indian Head Highway #2 Oxon Hill 9. Birthplace (State or West If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) Foreign West Country) Virginia **Funeral** Hours 05/16/1971 228-11-5708 37 Director 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. Count Yes 2 X No Maryland Prince George's Ft. Washington 23a or 28a-f show notified at once. death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20744 United States 8434 Indian Head Hwy., Apt B-2 14. Race - American Indian, Black, 11. Marital Status

1 Never Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. White, etc. Armed Forces?v If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 5 Specify: Black If Yes. Give Year 1 Yes 2 X No specify: hours after Widowed 4 Divorced other than "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72.1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Melwood 12 Contractor 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Austin B. Crawford Regina W. Berry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8434 Indian Head Hwy., Apt. B-2, Ft. Washington, MD 20744 Regina W. Berry/Mother 20c. Location - City or Town, State 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Pleasant View Memory Gardens 09/13/08 |Kearneysville, WV Other Specify: Donation 5 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee Tako 6160 Oxon Hill Road, Oxon Hill, MD 20745 m 23a/Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ailure. List only one cause on each line. /Medical Death Seizure disorder Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) and - transit The law requires that the death certificate be executed 23a,27,perME, g884 10/10/08 TT Physician/Medical X UNPENDED AMENDED the attending physician ed for use as the burial -Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, s been s 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of After this certificate has I uneral director, page 2 sh death? 2 No ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other: Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene DOA FR/Outpatient 3 Inpatient 1 V Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 5 Pending Yes 2 No filled in by the fi 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) To the Hospital o within 24 hours at To the Funeral D Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 10, 2008 O.C.M.E. -IMD

\*

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State

Registrar

30. Name and address of person who completed cause of death (Item 23a)

9 20

Assistant Medical Examiner

Regisar's Signature

Donna M. Vincenti, MD

31. Date filed (Month, Day Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		rtificate of			Reg. No. 2	108	30166	
	Physicia	an	Decedent's Name (First, Middle, La     ALGIE	st) DYSON		<u> </u>		2. Date of Dea	Day IBER 2 2	Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give		-	4b. City, Town, o	Location of Death	SEPIEM.		y of Death	2:30A M	
	Examin	E	MILLENNIUM HEAD	LTH & REHAB		SILVER				rgome i	RY	
	Funeral Director		217 10 22 0	6ex 7. Age ( <i>In yr</i> s. 1 X M 2 □ F 87	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da MARCH 2	th y, Year) 18 1921	9. Birthp Cour MAR	place (State or Foreign oftry) LAND	
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	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?	
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<u>Ya</u>		မ	WILLIAM A. DY		dob Maritim	Add (C4	MOLLY	ral Dauta Numb	DYSON	n Stata Zir	- Coda)	
Baitimore, Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship NANCY E. DYSON/W	IFE	1200	DELAWARE	and Number or Rui	5.W. # 8	319 WASI	HINGTO	ON, 26 <sub>024</sub>	
more			20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci	J Hemovai from State		sition (Name of matory or other place CREMATO)	1	2008	20c. Location	•		
Baiti	permit. Page Department of Important: If any injury or once.		A Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  21. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Fa									
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O. Box (	aath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 [	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	у			ate of deliv	rery Day Year	
ds, P.	w requires that the de s been signed by the should be detached	ρ	Part II. Other significant conditions  CANCER OF PROST		sulting in the u	nderlying cause giv	en in Part I.				the cause of death?	
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VIII	Physiclan: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	T ER/Outpatie	nt 3 17 DOA Oth	26. Place of Deal	th <i>(Check only c</i> ome 5 ☐ Resi		ther (Coo	(6.1)	
$\subseteq$	ng offe	l⊢ ⊹	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Inju			how injury occu			
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	De 280 Place of Injury - At h	nome, farm, str sify)	reet, factory, office		28f. Location (City or To	Street and Nun wn, State)	nber or Run	al Route Number,	
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			• WYV CON				51520		09-0	2-3	2000	
R	-(3)		30. Name and address of person who BAHRAM PISHDAI	completed cause of death (Ite D. M.D. 1328 SO			.E. WASHI	NGTON,	DC 200	)32		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 2008	32. Registrar's Sign	All Co.	-						

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ann Ε. Fryer September 2, 2008 5:35A \*\*/Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Collingswood Nursing Center Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🕅 F Yrs. Aug. 7, 1921 87 578-20-7269 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 24 No Funeral Director Maryland Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 11804 Eton Manor Drive 20876 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🛣 No Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vitro Labs. Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Ragland Eubank Telula Bayne ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wayne M. Fryer - Son 21223 Laywood Court, Richmond, Texas Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) 9/3/08 Metropolitan Crematorium Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Kine disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EISAYYAD lollo Malely 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.0

Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** George Frank Forbes, Jr. 2008 /Medical 4a. Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charles IVISTA La Plata 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | September 21,1919 Country | Maryland Social Security Number 7. Age (In yrs. last birthday, Funeral 1**▼** M 2□ F 214-12-1205 88 Yrs. Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any highry or other traumatic event, the Modical Evariation and be notified at once. **Maryland** Charles Bryantown 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20617 6500 Oliver Shop Rd. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Yes 2 No 1 □ Yes 2 No If res, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify. White Completed by Specify: 3 ₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Hauling Commercial Hauler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugenia Hall George F. Forbes, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Watlington Dr., South Boston, VA 24592 Barbara A. Francis/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Dominic 9/11/2008 Aquasco, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 21. Signature of Funeral Service Licens M00817 10 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate clause. Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DeUnknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 □Yes No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XINo 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1'Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Waldorf

Ste 102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patel

Year!

31. Date filed (Month, Day,

102 Paul

histrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Vaar Margaret Elizabeth Gross August 30 2008 1840 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Tracys Landing Anne Arundel 5983 Brooks Wood Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1 □ M 2 □ X F Director 86 MD 220-16-7747 April 8, 1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- " any injury or other traumatic exercises." 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 ☐ Yes 2 ☐ WNo Director MD Anne Arundel Tracvs Landing 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA Funeral 5983 Brooks Wood Road 20779 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ KNo Specify: Specify: 2 3 X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Carter Maynard Alice Creek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Rice - Niece 14522 Marlborough Circle, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carters UM Church 9/6/2008 Friendship, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Glady a. Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cabelic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner erebrovascular accid The law requires that the death certificate be executed burial-tra Box 68760 physician but antibotic resistant Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No. 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Urinary Irac Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Vital 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 ☐ Yes 2 ☑ No Division or funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in t 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Nancy Rivera-King,

5 2008

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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			For State Registrar	State of Marylan		rtment of H		d Mental H	lygiene Reg. No	2000	30171
N-	Physici		1. Decedent's Name (First, Middle, Last)  Dorothy Mae	Gray				2. Date of Month	Death Da		3. Time of Death  1:15 P M
	/Medio		4a. Facility Name (If not institution, give st Carol's Care Assis	reet and number)		4b. City, Town, or Springda			40	c. County of Death	
-	Funeral Director		5. Social Security Number 577-68-9542 6. Sex 1□	7. Age (In yrs. )	last birthday) Yrs.	If Under 1 Year Months Days			Day, Year,	Cou	place (State or Foreign ntry) Dama
	aryland show	Jr.	Usual Residence of Decedent  10a. State 10b. County		, Town or Lo						10d. Inside City Limits
	vith the M or 28a-f be notifie	Funeral Director	Maryland Prince Go	eorge's G	lenard	10f. Zip Code				tizen of What Cou	ntry?
	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		7932 Fiske Avenue  11. Marital Status  1 □ Never Married 2 □ Married	2. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 X No	S. 13. V	20706 Vas Decedent of His Yes, specify Cuba		? (Specify Yes or uerto Rican, etc.)		ited Stat 14. Race - Ameri Black, White,	
5-0036	'2 hours at hatural'', or ical Exam	by	3 Ma Widowed 4 ☐ Divorced  15. Decedent's Educa	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:			16b. k	Specify: (ind of Business/tr	American	
Baltimore, Maryland 21215-0036	filed within 7 Hygiene. Ither than "r Ithe Med	Completed	(Specify only highest grade Elementary/Secondary (0-12) 10 years	College (1-4or 5+)		kind of work done do NOT use retired, ewife					vate
yland	e d d	To Be	17. Father's Name (First, Middle, Last)  18. Mother's					Name (First, Mid larie Sn	-	n Surname)	
, Mar	12 ha 7 is		19a. Informant's Name/Relationship (Type Wilbert H. Gray, St	,		g Address (Street a Fiske Av					code)
more			20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	lace of Dispos emetery, crem	sition (Name of natory or other place Mem. Cemt	e) :	Date <b>5</b> t 8, 20	20c. L	ocation - City or Tuitland,	
Balti	permit. Pages Department of Important: If it any Injury or once.		21. Signiture of Funeral Service Lice re-	fault	MAIL	Name and Addres				cal Home,	
	Physician		23a. Part1 Enter the disease, or complic shock or heart failure. List only one Immediate C use (Final disease or condition	ations that caused the death cause on each line. Renal Fail	n. Do not ente						Approximate Interval Between Onset and Death 3 months
	/Medical Examiner	Examiner	resulting in death)	Due to (or as a consequ Diabetes M		s					20 years
2.	ocuted nd ransit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	Due to (or as a consequ	ience of):						
8/60,	cate be executed ohysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequ	ience of):				_		
O. Box 6	eath certifi attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specity)			-	23d. Date of deliv Month	ery Day Year
rds, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions control	ibuting to death but not resu	ilting in the un	derlying cause give	n in Part I.			_	the cause of death?
Vital Records,	e law has b	Completed	\\				_		itopsy erform <u>ed</u> ?	prior to co death?	opsy findings available impletion of cause of
_	nyslcian: nis certific director,	To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Ho	spital: 1	ER/Outpatient	3 DOA Othe		Death (Check on	ly one)	6 X Other (Speci	Senior Asst
DIVISION O	To the Hospital or Attending Pl within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral		27. Manner of Death  1 Anatural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗀 Y	at ? ∕es 2 □ No	28d. Descri	e how inju	ry occurred	
Š	ital or Att rs after de ral Direct led in by i	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	·)			City or	Town, State		
	the Hospi in 24 hou the Funei upletely fil	ledical	(Check only 2   Medical Examine one)	cian: To the best of my knower: On the basis of examinat and manner stated.	wledge, death tion and/or inv	estigation, in my of	oiníon, death o	ace, and due to foccurred at the tire	ne, date an	d place, and due t	to the cause(s)
)	S With S	Σ	29b. Signature and title of certifier	MO		29c. License D503				eptember	
L	6)		30. Name and address of person who com Kelvin B. Hao, M.I	). 14999 Heal	th Cen	,	, #201	Bowie,	MD 20	0716	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 2003	32. Registrar's Signat	feel	•					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Claudine Κ. Goodwyn /Medical August 28. 10:28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6201 Belwood Street District Heights Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 2 Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Min Months Days Hours Director 238-28-0497 83 1924 North Carolina 3, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George's 1 ☐ Yes 2 ☐ No District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6201 Belwood Street 20747 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed r than "natur the Medical ! 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Flomentary/Secondary (0-12) College (1-4or 5+) the Nurse ages 1 and 2 should be filed wi ont of Health and Mental Hygien It: If item 27 is marked other th y or other traumatic event, the Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cornelius Knight Lizzie Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathaniel Goodwyn II -8832 Hardesty Drive Clinton, MD 20735 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 ☑ Buriat 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parklawn Cemetery Sept 5, 2008 Rockville, MD 21. Si muture of une al Se vice Liber, es 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Ovarian Cancer Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence of) The law requires that the death certificate be executed Rectal Cancer and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign I be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 21 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 24 hours a Hospital 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 80-MD30151 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward Morris, M.D. 106 Irving St., NW #4800N Washington, DC 20010 31. Date filed (Month, Day, Year) 32. Registrar's Signa State SEP 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 12, A M William Henry Horman 2008 11:10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Northamoton Manor Frederick 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 15 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) Days Hours 98 Months 217-10-9610 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Frederick Middletown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 507 West Main Street 21769 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cream Buver Creamery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George W. Horman Mary Ellen Zimmerman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 Dominion Dr. #2D, Frederick, MD 21702 Rudy Horman / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland Resthaven Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Keeney and Basford Funeral Home, 106 E. Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service/Licensee e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dise shock, or heart failu e Fallure Immediate Cause (Final cart 24241 disease or condition resulting in death) Due to (or as a consequence of): 1000 hora Veaus Year death? Unknown available cause of

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Marnal Hygiens. Informative, or items 23a or 28e-f show Important: If item 72 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Maclical Examiner must be notified at

Baltimore, Maryland 21215-0036

/Medical

10a. State

physician and s the burial-trans attending p for use as 1 within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital or Attending Physician: The law requires

Division of Vital Records, P.O. Box 68760,

Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown	23c. If yes, outcome of pregnancy  1				23d. Date of delivery Month Day	Yea
Completed by Ph	Part II. Other significant conditions	contributing to death but not resulting	in the underlying caus	e given in Part I.		24b. Were autopsy fin prior to completic death?	4 ☐ Unk idings ava on of caus
Be (	25. Was case referred to medical			26. Place of Dea	ath (Check only one)		
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2   ER/	Outpatient 3 DOA	Other: 4 Nursing H	forme 5 ☐ Residence	e 6 ☐ Other (Specify)	
ation: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b	Time of 28c.	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred	
Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		farm, street, factory, of	fice	28f. Location (Street City or Town, St	t and Number or Rural Route tate)	e Number
Medical (		hysician: To the best of my knowled miner: On the basis of examination and manner stated.					ause(s)
₹ K	20h Signature and title of obrtifier		290 1	cense number	291	Date signed (Month, Day, Y	(ear)

State Registrar

29b. Signature and title of pertific

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

610 32 Registrar's Signature

29c. License number

D 22037

29d. Date signed (Month, Day, Year)

AVE Branswice MD21716

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2008 Sept Thomas Edward Horstkamp Sr. 3, 10:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1505 Amherst Road West Hyattsville Prince George's 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country)
August 13,1920 Washington, DC Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1 X M 2 □ F 577-18-4470 88 August Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Maddal Even in a the positified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Prince Georges West Hyattsville 10e. Street and Number 10g. Citizen of What Country? 20783 Funeral 1505 Amherst Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ۵ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Prime Corp 12 Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Nicholas Horstkamp Elizabeth Wheland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Horstkamp - Wife 1505 Amherst Rd, West Hyattsville, Md 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) St. Marys Catholic Cemetery Sept 8,2008 Washington, D.C. 21. Signature of Functial Service Licensel 22. Name and Address of Facility 4739 Baltimore Ave. KKKS Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ned by the sidetached for 1 □Yes 2 □No 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Llaknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 a autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner / Feath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hittural 5 Pending investigation ieral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, 7701 Carroll Ave, Takoma Park, MD 31. Date filed (Month, Day, Yea. 32. Registrar's Signat State SEP 0 8 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:20 P M HARRISON AUGUST 31 2008 **JOHN** Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND SUBACUTE UNIT PRINCE GEORGE'S CLINTON 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 1 M 2 □ F MARCH 22 1938 WASHINGTON, DC Director 70 220-32-6674 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 28a-f show Examiner must be notified at X Yes 2 □ No Director MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? with 6 23a USA 3037 CHESTER GROVE ROAD 20774 Funeral death items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2 🕅 No Specify: Specify: BLACK þ 'naturai", Completed traumatic event, the Wedical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSE MAN PRIVATE 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Is marked of and 2 should be JOHN E. HARRISON JOSEPHINE HOLIDAY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S f Health a tem 27 Is GINGER WHITFIELD/DAUGHTER 1921 VERMONT AVENUE LANDOVER, MARYLAND 20785 Pages 1 ment of H 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9/8/2008 LINCOLN CEMETERY SUITLAND, MARYLAND J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on: Physician: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery atten for u Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending after death.

Director: Af
d in by the fur investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a Medical 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 70 ECD LINE W (5875)CC

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SSAN a Cephus Hargrove, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 X M 2 □ F NC Director 8/17/1952 578-70-5396 56 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 No Director Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 20774 USA 13304 Burleigh Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ٥ Specify: **Black** 3 Widowed 4 Divorced "natural" Completed 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any Injury or other traumatic event, the Manages Elementary/Secondary (0-12) College (1-4or 5+) US Postal Service Mail Carrier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucy Small ပ Cephus Hargrove, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 13304 Burleigh St, Upper Marlboro, MD Jacqueline Ashton Hargrove/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 9/8/2008 Landover, Maryland 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 Ninth Street, NW Washington, DC 20011 23a. (earl.). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): **To the Hospital or Attending Physician:** The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No ours after death.

neral Director: A
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State

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30. Name and address of person who completed cause of death/(Item 23a),(Type, Print)

Broo.

Year)

31. Date filed (Month

3001

41051 32. Registrar's Signature 42183

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUG 30 2008 **Physician** JOHN EASTMAN HOLT 6:13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F 59 224-64-8919 California Director 3/16/1949 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State fshow "natural", or Items 23a or 28a-f shordical Examiner must be notified at 1 □Yes 2 No Director Charles Town W.V. Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25414 USA 212 Straithmore Farm Ln. by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1970-90 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White 3 ☐ Widowed 4 🗓 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) with and Mental Hyglene.
27 Is marked other than "
r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Major Military years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Harrison Holt Anne Austin Gayle ဂ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Hea 2636 Quiet Water Cove, Annapolis, MD 21401 Anne G. DeWitt/ Mother altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of h Important: If Ite any injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 9/4/08 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu 3 by Juny al Ser ce Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral I tX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 **FUHRER** MÇ USN GREGORY S.

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2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Cynthia Jackson September 2008 /Medical 11:00 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Bethesda Manor Care at Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9/16/1925 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☐ F Director 579-32-4405 82 NC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits r then "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes X☐ No Directo VA Stafford Stafford 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3 Ludwell Lane Funerai 22554 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. importent: if frem 27 is marked other then "naturat", or its any injury or other treumatic event. Its Madical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specity: Black 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Home Health Aide <u>Upjohn Healthcare Serv</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Wiggs Pennie Wiggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Ludwell Lane Stafford, Virginia Oliver Thomas/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 9/8/2008 Landover, Maryland 21. Signature of Funeral 22. Name and Address of Facility Marshall's Funeral Home 4217 Ninth Street, NW Washington, DC Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part1 s lock Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Aspiration Pneumonia /Medical resulting in death) Due to (or as a consequence of): **Examiner** Dysphagia Sequentially list conditions. Examiner Due to (or se a consequence of) any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed as the burial-transit Cerebral Vascular Accident Secondary resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical to Intracranial Hemorrhage July 2008 use a IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown as been signed by 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy page 1 ☐ Yes 2X No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: XX Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2₹ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural within 24 hours after usan.

To the Funerel Director: Aft 5 Pending investigation 2 🗌 No 2 Accident 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04108 D35579 3 30. Name and address of person who compl ted cause of death (Item 23a) (Type, Print) Susan J. Miller, MD 8218 Wisconsin Ave #305, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) SEP = 5 32. Registrar's Signature State 2008 1381A. Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** AUTUMN MICHELLE KILLGO SEPTEMBER 1, 2008 16:10P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE CLINTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 M F Director <u>218-82-8067</u> JAMESTOWN, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exprement must be motified at Director MD PRINCE GEORGE FORESTVILLE ¶Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4828 LARWIN DR 20748 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after Hygiene. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2√ No Specify. Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISABLED NONE 12 should be filed with and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CRAIG C. KILLGO FRANCES PAULETTE BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a FRANCES P. KILLGO/MOTHER 2010 OLIVER ST HYATTSVILLE, MD 20782 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 109-06-2008 RIVERDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic adenocasicinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, i.e. in the language. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burlal-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 cerebral 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performe Physician: The certificate 2 N 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 11 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 1 Vatural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 | Pending in 24 hours after www.in 24 hours after birector; After the further filled in by the further f 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 MD Viruman D63183 102/2008 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLINTON -ROAD CURRATTS 7503 20735 SHRI KANNAN YWAY 31. Date filed (Month, Day, Year) 32. Registrar's Sign State SEP 0 8 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** September 6 2008 CYRUS ROSCOE KEPLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FAHRNEY-KEEDY MEMORIAL HOME BOONSBORO WASHINGTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 🔀 M 2 🗆 F 214-09-3851 SEPT. Director 91 18,1916 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian 8507 MAPLEVILLE ROAD <u> 21713</u> by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 SALESMAN HARDWARE STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN HAMILTON KEPLER SADIE E. SCHILDTKNECHT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN A. ISEMINGER/DAUGHTER 19805 EVELYN AVENUE, HAGERSTOWN, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 5 Other (Specify) 4 Denation 9/11/2008 BOONSBORO CEMETERY BOONSBORO, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME, PA 21. Sign Paul M. Dean 7606 Old National Pike, Boonsboro, MD 21713 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Gera brovascula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of):

**Physician** /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Division or Vital Records, P.O. Box 68760,

. 1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
ompleted by FI	Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobacc  1 ☐ Yes  24a. Was an autopsy performed 1 ☐ Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of death?
0 -	25. Was case referred to medical	1		26. Place of De	ath (Check only one)	
	examiner? 1 ☐ Yes 2∰-No	Hospital: 1   Inpatient 2	☐ER/Outpatient 3☐	DOA Other: ANUrsing I	Home 5 ☐ Residence	e 6 □Other (Specify)
allolli.	27. Manner of Death  11 → Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	
	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		nome, farm, street, fact	ory, office	28f. Location (Street City or Town, S.	and Number or Rural Route Number, tate)

29c. License number

1126 Opal Court, Hagerstown, Maryland 21742

29d. Date signed (Month, Day, Year)

09-07-2008

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Khalid M. Waseem, M.D.

SEP 1 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** COSTINA MASON 14:58 09 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bethesda Suburban Montgomery Hospital Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 19 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔽 F Months Days Hours Min 577-38-3108 79 1928 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location or 28a-f show traumatic event, the Medical Examiner must be notified at Washington Director DC toryes 2 □ No the 10f. Zip Code 20019 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Modical Examiner must he may Injury or other traumatic event, the Modical Examiner must he may Chaplin Street SE USA 4332 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐Yes 2 ☑ No Specify: à 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Bindery Helper 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEE PINKEY MANLEY **EZRA** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4332 Chaplin Street SE, Wash, DC 20019 Katana Simmons Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Memorial Cemetery 9/9/2008 Suitland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Bianchi 814 Upshur St NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Cerebral Anoxia Days /Medical Due to (or as a consequence of) Examiner Myocardial Infarction Days Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Atherosclerosis <u>Gereralized</u> Years burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) the 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 ☐ Unknown Hypertension 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes Mellitus 24a Was an autopsy performed? 1 Tes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1XX Natural 5 Pending investigation 1 ☐Yes 2 ☐ No n 24 hours after death.

le Funeral Director: A pletely filled in by the fi death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 5454 Wisconsin Averice, Chery Chur Miry land State Registrar

08-07002	44	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental Hy	es Are Le	gible	. 2.0	008 3018
Steven E. McDerr		For State Of Waryland / Department of Fleath and Wishland F.		Reg. No.	20	100 3010
		gistrar Decedent's Name (First, Middle,Last)	2. Date of Dea	ath	Year	3. Time of Death
Physician Medical Examin	-		Month Septemb	er 13, 2	2008	1235 hrs
		Steven Eugene McDermott  a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death			County of Dea	ath
		28 West Main Street, Apartment 5 Hancock			/ashington	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	_	irth(MM/E	Fore	Birthplace (State or eign
Director		15-88-0914 1X M 2 F 39 Yrs. Months Days Hours Min	Septent	er 2	7.1968 <sup>°</sup>	Country) MD
		Isual Residence of Decedent				10d. Inside City Limits
any	Γ	0a. State 10b. County 10c. City, Town or Location				1 X Yes 2 No
show are	اۃ	MD Washington Hancock		10a Citi	zen of What Co	
with the Maryland ms 23a or 28a-f show be notified at once.	Director	0e. Street and Number 10f. Zip Code			LETT OF WITHER O	
the N		28 West Main Street, Apartment 5 21750		USA	14 Page - Am	nencan Indian, Black,
r death with the or items 23a c	Funeral	1. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	VO-	White, etc	
death or ite	5	Never Married 2 Married 1 Yes 2 X No 1 Yes 2 Y No specify:			Specify: Whi	ito
after	b	Wildowed 4 X Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of the property of the propert	work done		Kind of Busines	
hours	60	15. Decedent's Education (specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  College (1-4 or 5+)	tired)			
36 in 72 han "fical	be	12 Cook		Re	staurar	nt
5-0036 fled within 77 Hygiene. d other than	Completed	17. Father's Name (First, Middle, Last)  18.Mother's Name	ne (First, Middle	e, Maiden	Surname)	
215- be filed antal Hy rked of	Be	Danald McDarmott	n Jacob	s		
212 212 Ment Ment mark	ToE	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of				tate, Zip Code)
MD td 2 sho tlth and m 27 is aumati		Carolyn Barkdoll/Mother 12617 Seavolt RD Hand	COCK , M.	D 21	750	y or Town, State
e, F   and   Healt   item		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	200.	Location - On	y di Tomij otato
more, MD 21215-0u36 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Ant: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Rose Hill Cemetery 09	/17/200	18 Ha	gersto	m MD
Baltimore, MD 21215-0u36 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". injury or other traumatic event, the Medical Examiner.		21 Signature of Funeral Service Licensee 22. Name and Address of Facility	141 WEs	t Ma	in Str	eet
ii ji ji ji ji ji ji ji ji ji ji ji ji j		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	P.A.F	lanco	ck MD	21750-0368 Approximate Interval
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as caldial failure. List only one cause or each line.	orrespiratory	arrost, or	10011, 01 110011	Between Onset and Death
*Medical aminer		Immediate Cause (Final disease a. Ethanol Intoxication				
tailinei		or condition resulting in death)  Due to (or as a consequence of):				
	<u></u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	Examine	cause Enter Underlying Cause	1511			
=	xal	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
scuted and transit	జ	AMENDED 23a,27, 28a-f per me g884 10	)-17-08	vt		
be exc ician urial	👸				3d. Date of de	livery
cords, P.O. Box 68760, law requires that the death certificate be execute that been signed by the attending physician and 2.2 should be detacted for use as the burial - trans	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	gnancy		Month	Day Year
68 certif	ia.	past 12 months?  Pregnant at time of death 5 Other (Specify)		- 4		
Sox death he atte	ysi	1 Yes 2 No 9 Unknown g Unknown	1			ite to the cause of death?
O. E. at the laby the tached	무	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				Probably 4 Unknown
P.O. es that the signed by be detac	à					ere autopsy findings available
ds, requir	Completed		a	Vas an iutopsy	pric	or to completion of cause of
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Re : The ificate	වි	25. Was case referred to medical 26.Place of Death (Che	eck only one)			
of Vital Recing Physician: The Affer this certificate Runeral director, page	Be	examiner? Hospital: 1 Innatient 2 ER/Outpatient 3 DOA Other Nu	rsing Home 5	Resi	idence 6 🗸	Other: Scene
of V Physicithi eral di	<u>P</u>	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	28d. Desc	ribe how	injury occurred	<u> </u>
or C nding th.	5	1 Natural 5 Pending 9-13-08 10:30 am 1 Yes 2 x No		cnown		
IVISIOR OF Attendather death Director:		2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Locat	ion (Stree	t and Number	or Rural Route Number, City
Division of Vital Records, riple or Attending Physician: The law require ours after death. renal Division: After this certificate has been signified in by the funeral director, page 2 should be	Certification:	Suicide Suicide determined (Specify) house	_			ck, Md . Apt 5
		Of Cotified	and due to the	cause(s)	and manner a	s stated.
To the Hos within 24 h	Medical	Certifying Physician: To the best of my knowledge, death occurred at the line, date and place, (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time,	date and	place, and du	e to the cases(s)
To To To To To To To To To To To To To T	N N	29b. Signature and title of certifier 29c. License number		29	ld. Date signed	(Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD.

State 31. Date filed (Month, Day, Year) Registrar

22. Registrar's Signature

O.C.M.E.

September 14, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mackey SR.

4b. City, Town, or Location of Death Richard Sep tomber 1435 /Medical 7 200 8 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 05/15/1943 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1 <del>Q</del> M 2 □ F 067-34-8700 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1797 Stonegate Avenue 21114 Funeral United States 12. Was Decedent Ever in U.S. Anyoned Forces? 1 △ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1967–69 Specify: White 1 ☐ Yes 2 💢 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Executive Director Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othn any Injury or other traumatic event, Be Jacob T. Mackey Sophie Crodelle ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Mackey/Wife 1797 Stonegate Avenue, Crofton, Maryland 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Entombment Lakemont Memorial Gardens 09/06/2008 Davidsonville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cartiopulmonary
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner respicatory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-tran resulting in death) Last Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at ild be detached for 5 Other (specify) Yes 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by syptogenic circhosis 1 Yes 2 No 3 Probably 4 Unknown page 2 should 40162 Stenosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 No 1 Tyes 1 Yes 25. Was case referred to medical examiner? or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 ☐ No ٥ 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. М 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only Medical completely To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 September 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khandker 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2008 Gorde Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 **Physician** 1035 AM 1001 losgoro /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ma 9. Prthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🙀 F Months Days Hours Min Yrs Director 579-40-6458 11 1931 Aug. Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ▼ No 28a-f Maryland Montgomery Rockville filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 20853 4604 Eades Street Funeral USA or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 N Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Specify. ş Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 7 is marked other traumatic event, II Own\_Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Alvah A. Raley 2 Mary Margaret Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health 8 Important: If item 27 is any injury or other tra John Moore/Husband 4604 Eades Street, Rockville, MD 20853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sept. 2008 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Q Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Tros Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Songeril Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): and burial-trar Division of Vital Records, P.O. Box 68760, the aftending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 □ Yes 2 □ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐No after death Director: filled in by the 6 ☐Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the within 2

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

375 5 OFF

29d. Date signed (Month, Day, Year)

300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0832 M 26 arra iana 2008 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12-25-84 5. Social Security Number 7. Age (In yrs. last birthday)
23 Yrs. If Under 1 Year | If Under 24 Hrs. | **Funeral** 1 - M 2XX Days Hours New York 461-70-4107 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 □ No n/a D.C. Washington 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò 609 Ouincy Street, N.W. 20011 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🔽 No Specify. 2 Specify: Hispanic 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) be filed within al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be t and Mental h Is marked Vincent Harrison Kathren Marra permit. Pages 1 and 2 should I Department of Health and Menimportant: If Item 27 Is marken 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent Harrison/Father 609 Quincy St. NW D.C. 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pigury on 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gates of Heaven 9/5/08 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Md. 21. Signaty e of Funeral Service Licensee 22. Name and Address of Facility The House of Williams Willener 814- Upshur Street, N.W. 7 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 - Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) 2 No P.O. the Unknown 9 Unknown ģ contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Til Yes 2 Do 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 les 2 l No Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending P s after death. I Director: After ti Division 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident the 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

29b. Signature and title

30. Name and address of

31. Date filed (Month Pay

5 2008

To the within 2

Registrar DHMH 17 Rev 1/2001 600 North Wolfe St, Baltimore, MD, 21287

se of death (Item 23a) (Type, Print)

and manner stated

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Year Ellen Maraio September 3, 2008 4c. County of Death Olney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Months Days Hours 1 □ M 2 🔀 F Aug. 31. 1946 Pennsylvania 10d. Inside City Limits

1 ☐ Yes 2 17 No

Approximate Interval Between Onset and Death

Day

2 No

1 ☐Yes

MINUIES

Year

White

1. Decedent's Name (First, Middle, Last) **Physician** Ruth /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery General Hospital 5. Social Security Number **Funeral** Director 173-36-6820 Usual Residence of Decedent 10b. County 10c. City, Town or Location Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. "natural" or items 23a or 28a-f show amortant: If item 27 is marked other than "natural" or items 23a or 28a-f show amy injury or other traumatic event, the Macinel Examinar Leans filled at once. Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5306 Manorfield Road 20853 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 TNo Specify: <u>δ</u> Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Myers ၉ Rose Guthery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Maraio/Husband 5306 Manorfield Road, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 6, Sept. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Marylan¢ 22. Name and Address of Facility 21. Signaly re of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIAC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner B. LEEDIN Sequentially list conditions if any could be cause. Enter Underlying Cause (Disease or injury that initiated events Examiner METASJASIS The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) physician at the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 ☐ Other (specify) Ö the 9 Unknown 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed? Yes 2 No certificate 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Medical Certification: To 1 Inpatient After thi funeral o 27 Manner of Death 28a Date of Injury 20h Timo of neral Director: / filled in by the f within 24 hours a To the Funeral C completely filled

1 ☑ Natural 2 ☑ Accident	5 Pending investigation	(Month, Day, Year)	Injury M	Work'	es 2 □ No	260. Describe	show injury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office			(Street and Number or Rural Route Number, wn, State)	
29a. Certifier (Check only one)	Certifying Physi	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the tim on, in my op	ne, date and place pinion, death occu	e, and due to th urred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)	
29b. Signature and ti	tle of certifier	1.		9c. License	number		29d. Date signed (Month, Day, Year)	
) R	abest	t. Larke	n MID	D	1981	5	9/3/2008	
	ss of person who com	npleted cause of death (Item MD 18101	n 23a) (Type, Print) Prince Phi	ilin D	rive O	lnev Mi	n 20832	

State Registrar 31. Date filed (Month Day 32. Registrar's Signature Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ${f 2} \ {f 0} \ {f 0} \ {f 8}$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 200 \_MOATS ROBERT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**½** M 2 □ F Director 86 17, 1921 MARYLAND <u>217-12-2244</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. inside City Limits 10a. State 1 ☐ Yes 2 ▼ No Director MARYLAND WASHINGTON BOONSBORO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A.
Race - American Indian, Funeral 7729 SHARPSBURG PIKE 21713 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Specify. þ 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 MILL WORKER FEED MILL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAMIE E. (UNKNOWN) HENRY DAVID MOATS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11314 ROBINWOOD DRIVE, HAGERSTOWN, MARYLAND DENNIS MOATS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XBurial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) ST. MARK'S CEMETERY 9/10/2008 BOONSBORO, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME 21. Signature of Pun-Paul M. Dean 7606 Old National Pike, Boonsboro, MD 21713 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) HYPOTENSION Due to (or as a consequence of): HEART FAILURE CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ACUTE ON CHRONIC RENAL PAILURE Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ

**Physician** /Medical **Examiner** 

Baltimore, Maryland 21215-0036

sician and burial-transit or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: A
filled in by the fu within 24 hours at
To the Funeral E
completely filled is

Be

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

Completed

25. Was case referred to medical examiner?

1 Yes 277No

27. Manner of Death

1 Naturai 2 Accident

3□ Suicide

29a. Certifier

4 Homicide

1. Inpatient

28a. Date of Injury (Month, Day Year)

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗌 No 2 1 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MOHAMNED 4212

066892

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251 East Antietam Street, Hagerstown, Maryland Mohammed Aziz, M.D. 31. Date filed (Month, Day, Year)

28c. Injury at Work?

State Registrar

SEP 1 0 2008

5 Pending investigation

6 ☐ Could not be

determined



To the Hospital

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Catharine McCance September 8, 2008 3:15 p <sup>M</sup> Ninetta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Solomons Nursing Center Solomons | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April | 8, 1911 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X 97 Pennsylvania **Director** 578-28-8636 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be retified at Director 1 ☐Yes 2 ▼ No Maryland Charles **Hughesville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7042 Bluebird Hill Place 20637 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ Specify: White 3 ¥Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Ewing Lumber Yard 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Plum Etha Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Burroughs/Granddaughter 13275 Ryceville Rd., Charlotte Hall, MD 20622 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Sept. 10. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2008 Charlotte Hall, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lic Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days neumer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 Yes 2 Who Year Month Day 5 ☐ Other (specify) Ö the 9 Unknown 9 Unknown signed by to σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Records, þ FIBRILLATION JENONSET ATRIAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed CONGESTIVE HEART 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 s autopsy certificate 1 □ Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this s after death.
I Director; After this d in by the funeral d 27. Manna Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ical Certification: I or Attending Fatter death. Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier 6

ANWAR 31. Date filed (Month, Day, Year)

ORIGINAL

110

32. Registrar's Signature

HOSPITAL

Ulondis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUNSHI.M.D

29d. Date signed (Month, Day, Year)

ROAD PRINCE

08-06540 Patricia Naugle	/	Please Type or Print in Black Indelible Ink. Ensure All Copies		ble.	
Z Ratricia Naugie		State of Maryland / Department of Health and Mental Hyg  1- For State  Certificate of Death		200	8 3019
Physicia	an/	Registrar	Date of Death	No. ZUU	3. Time of Death
Medical Exami	ner		August 27,	2008 4c. County of Death	0834 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  502 Orchard Manor Drive  Bodnsbord		Washington	
Funeral			8. Date of Birth	(MM/DD/YYYY) 9. Birt	
Director		220-34-1172   1 M 2XF 70 Yrs.   Months   Days   Hours   Min.	June	17,1938	untry) MD
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<b>*</b>	اِ	MD Washington Boonsboro			1 XYes 2 No
darylau 28a-f	Director	10e. Street and Number 10f. Zip Code	100	. Citizen of What Cour	
reath with the Maryland or items 23a or 28a-f show must be notified at once.	ä	502 Orchard Manor Dr. 21713		USA	
eath wi	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Version Specific Cuban, Mexican, Puerto Ri		14. Race - Amen White, etc.	can Indian, Black,
after de al", or	by Ft	3 Widowed 4XXDivorced of Yes, Give Year or Datas:		Specify: Whi	te
hours		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of wor during most of working life. DO NOT use retired		16b. Kind of Business/I	ndustry
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 homemaker		own ho	ome
215-0036 be filed within 7 tral Hygiene. *ked other than ent, the Medica	Con	17. Father's Name (First, Middle, Last)  18.Mother's Name (F			
121 d be fil lental I arked	Be	John Herman Harshman Elsie I			
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	To	19a. Informant's Name/Relationship (Type, Print ) Wayne A. Baker (Son)  19b. Mailing Address (Street and Number or Rui 1253 Magnolia Ct.,			
e, N 1 and 2 Health Fitem 3		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If iter		1 X Burial 2 Cremation 3 Removal from State Pleasant View Cemetery  4 Doubtion 5 Other Specify:	79/2/0	8Burkitts	ville, MD
Salti ermit. Separtm mports njury o		2/. Signature of Funeral Service Library e	son F	uneral Ho	me
Physician	_	POB 18, Middle to a sale of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respectively.	OWI,	MD 41/09	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiova			Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate  b			
	Examiner	cause. Cuter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transit	Ä	d.			
ਹ ਜ਼ਿਲ <b>਼</b>	dical	X UNPENDED 23a,PII,27,perME, g883 9/22/08	TT		
OX 68760, sath certificate be exattending physician for use as the burial.	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy	cv	23d. Date of deliver Month	y Day Year
ox 6	sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
D.O, BO) that the deat ned by the att detached for	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
S, P.O. Bc nires that the dea n signed by the a	d by	Clinical history of chronic obstructive	1 Yes	2 No 3 Pro	bably 4 Unknown
of Vital Records, ing Physician: The law requii After this certificate has been a luneral director, page 2 should	Complete	pulmonary disease	24a. Was a		utopsy findings available completion of cause of
Recc The lav	mo		perform 1 <b>V</b> Yes 2		es 2 No
tal F cian: certifi ector,	Bec	25. Was case referred to medical examiner?  Hospital: Inspiral 2 EP/Quitabliant 3 DOA Other Nursing			
of Vi Physi ter this	<u>د</u>	1 Yes 2 No Impatent 2 Exocupation 3 DOX 4 Norsing		Residence 6  Othe	r: Scene
OD C ending ath. or: Af the fun	tion	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
or Att or Att after de Direct	Certification:	Suicide Could not be	28f. Location (Story Town, St.		ural Route Number, City
Di Spital hours a meral y filled		4 Homicide determined (Specify)  29a. Certifier 1 Certifier Physician: To the best of my knowledge, death occurred at the time date and place, and determined to the control of the best of my knowledge, death occurred at the time date and place, and determined to the control of the best of my knowledge, death occurred at the time date and place, and determined to the control of the best of my knowledge, death occurred at the time date and place.			
Division of Vital Records, P.O. Box 68760, vitin 24 hours after death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director.	Medical	(Check only one)  2 Windical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and death occurred at the time, date and de			
To To con	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	nth, Day, Year)
		O.C.M.E.		August 28, 2008	
		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
St	ate		£ 1£V1		
Regist		10 6.0 40 40			

DHMH 17 Rev 1/2001 OCME 2006

08-06540

**ORIGINAL** 

Months

Age (In vrs. last birthday)

97

4h. City. Town, or Location of Death

Potomac

If Under 1 Year If Under 24 Hrs.

Hours

Min.

Days

3. Time of Death

9. Birthplace (State or Foreign

"York

4c. County of Death

8. Date of Birth (Month, Day, Year) 6 / 1 4 / 1 9 1 1

Montgomery

New

1:45a

**Physician** /Medical Examiner **Funeral** Director

For State Registrar

Helena

5. Social Security Number

215-44-8496

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

6. Sex

1 □ M 2 12 F

Manor Care Potomac

the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed use as the burial-tran and s been signed by the attending physician should be detached for use as the buria has After this certificate To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

P.O. Box 68760.

Division or Vital Records.

10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. Counts MD Montgomery Silver Spring 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 3270 Gleneagles Drive by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify White 3 Nidowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unk. Kryzynski ဂ္ 19a. Informant's Name/Relationship (Type. Printaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline O.Blandford/ 11902 Jubal Early Court Potomac, Md. 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 9/02/2008 Beltsville, Md Chesapeake Crem 4 Donation 5 Other (Specify) PHILIPADS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stage 4 sacral Due to (or as a consequence of): Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Congestive heart failure Due to (or as a consequence of) Hypertension Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown Hyperlipodemia 24b. Were autopsy findings available prior to completion of cause of Hypothyroidism 24a. Was an autopsy performed? /es 2 No death? 2□ No 1⊟ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4N Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20274 Sept.2,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7710 Bradley Blvd. Bethesda, Md 20815 Vohra MD Kirti 32. Redistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month Pay Year)

5

2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** James Russell Reid Jr. Sept. 9, 2008 7:30 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1114 Murdock Avenue Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 216-14-7000 86 **Director** July 26, 1922 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the World Experiment and the notified at Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 1114 Murdock Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify If Yes, Give Year or Dates: WW II Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within ; th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 11 salesman plumbing 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Russell Reid Sr. Cora Naomi Keefer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur Evelyn Reid - wife 1114 Murdock Avenuer, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 9/12/08 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cocrection 141.9 monds disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. the 1 ☐Yes 2 ☐No detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed The certificate | 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral To the Hospital or Attending Pl within 24 hours after death. ➤ To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Campus Michael orneck 11110 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State **SEP 10** Registrar

			Plea	se Type or									Legible.		
		For State		State o	f Ma	ryland	-	artment of					2008	30193	
		State Registrar  1. Decedent's Name	e (First. Middle	e. Last)			Ce	rtificate of	Deal	<i>n</i>	2. Date of De	Reg. No. ath	2000	3. Time of Death	
Physicia /Medic				Henry Ruc	:h						Septem	iber <sup>Day</sup>	2, 200	08 1:00 PM	
Examin		4a. Facility Name (If	f not institution	n, give street and nu	mber)	Dob	a la	4b. City, Town,					County of Dea		
Franci		5. Social Security Nu		ur Health			ast birthday		napol	er 24 Hrs.	8. Date of Bir	th	9. Bir	thplace (State or Foreign	
Funeral Director		578-03-9		1 □ M 2 <b>X</b> XF	98		Yrs.	Months Days	Hour	s Min.	May 2,	y, Year)	L Co	nington D.C.	
and w		Usual Residence of 10a. State	Decedent 10b. County		-	10c. City	, Town or L	ocation				10d. Inside City Limits			
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and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at		Martha G.			ce			7 Garfie			Monkton,				
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.		21. Signature of Fu	neral Service	Licensee 2			1	22. Name and Addi				-		al Home,Inc. , MD 21401	
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tal or safter al Dire	Certification:	4  Homicide	determ	build	ting, etc	c. (Specif	y)				City or To	iwn, State	e)		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	Certifyi	ng Physician: To the Examiner: On the	basis o	f examina	wledge, de tion and/or	ath occurred at the investigation, in my	time, dat y opinion,	e and place death occu	e, and due to the urred at the time	e cause(s , date and	s) and manner d place, and di	as stated. ue to the cause(s)	
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			. POI		nd / Dep	artment of H	lealth and			e.
			1 - State Registrar		Ce	rtificate of	Death		Reg. No. 2 (	08 30 91
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Rubert Resico					2. Date of De Month		3. Time of Death 9
	Examin	er	4a. Facility Name (If not institution, give street and r			2	r Location of Deal	th	4c. County of I	Death
			University of Maryland M 5. Social Security Number 6: Sex	7. Age (In yrs.		Batter If Under 1 Year		i. 8 Date of Bi	rth a	Birthplace (State or Foreign
	Funeral Director		377-46-9910 1⊠ M 2□ F	60	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year) 26, 1947 M	Country) Lichigan
	yland now		10a. State 10b. County	10c. Ci	ty, Town or L	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland St. Mary's			Leona	rdtown			1 □Yes 2 🛛 No
	th with the 23a or 28	<b>Funeral Director</b>	10e. Street and Number 39865 Lady Baltimore A	venue		10f. Zip Code 206	50		10g. Citizen of Wha	it Country?
215-0036	2 should be filed within 72 hours after death with the Maryland and Menth Hyglene.  amd Menth Hyglene.  amarked other than "natural", or items 23a or 28a-f show as marked other than "natural", or items 20a or 28a-f show as marked event, the Medical Examination and the profiled at	by	Armed	: 2 □ No Bive	.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (\$ an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	Black, V	American Indian, White, etc. White
Š	2 hou	ted	15. Decedent's Education		16a. Dece	edent's Usual Occup	pation		16b. Kind of Busin	ess/Industry
2121	d within 7 giene. ir than "r	Be Completed	(Specify only highest grade completed   Elementary/Secondary (0-12)   College   1 2	(1-4or 5+)	life.	e kind of work done DO NOT use retire ail Sales	d)	rking	Home Impr	ovement Store
		Be C	17. Father's Name (First, Middle, Last)						, Maiden Surname)	
yia	Ment Ment arkec	2	Frederick Joseph Resico	) ——————				Louise	Pringnitz	
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)			ing Address <i>(Street</i> 5 Lady Ba			ber, City or Town, Sta	ate, Zip Code) own, MD 20650
e T	1 and Healt em 2		Sherry Marie Resico / W					Date	20c. Location - Cit	
ē E	ages ent of it: If it		1X Burial 2 ☐ Cremation 3 ☐ Removal from	II State		osition (Name of ematory or other place emorial Gard	tone bept	tember 10,		
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ed once.		21. Signature of Funeral Service Licensee	011		2. Name and Addre	ess of Facility	2008	I	
ă	Per Imp		Muchaeltka	dnie	ا رہـٰ	Mattingle, P.O. Box	y-Gardiner 270 Leona	Funeral H rdtown, MI	Iome, P.A. 20650	
	Physician /Medical		resulting in death		Pancre		ng, such as cardia			Approximate Interval Between Onset and Death
	Examiner	er		o for as a conse						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
60,	te be executed ysician and e burial-transit	al Exa	Due to (or as a consequence of):							
20	ificate g phys is the	edic	d							
O. BOX	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  with the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	Physician/Medic	in the past 12 months?	utcome of pregn e birth 2  Feta egnant at time of known	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	ey .		23d. Date o Month	•
 7.	that ned by detail	by Ph	Part II. Other significant conditions contributing to	death but not res	sulting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
ecords,	quires an sign uld be							10	Yes 2 No 3	Probably 4 Unknown
ည္သ	aw re as bee 2 sho	Completed						24a. Wa		re autopsy findings available
ř	The ate his page	mo;						perf	ormed? dea	r to completion of cause of th?  Yes 2 □ No
VII III	clan: ertific	Be (	25. Was case referred to medical examiner?				26. Place of De	ath (Check only		
5	Physi this o	မ		Inpatient 2			4 LI Nursing I		idence 6 Other	(Specify)
SION	ding I h. After funer	ion	1 Natural 5 Pending (Mo	e of Injury onth, Day, Year)	28b. Time of Injury	Wor	ryat k? Yes 2 ∐ No	28d. Describe	how injury occurred	
MINIST	or Atten after deat Director; in by the	Certification:	a Doublide 6 D Could not be	ce of Injury - At h ding, etc. <i>(Speci</i>	l ome, farm, st ify)	treet, factory, office	ites Z   No	28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
	e Hospital 24 hours e Funeral letely filled	Medical Ce	29a. Certifier 1	he best of my kno basis of examination	owledge, dea ation and/or i	ith occurred at the ti nvestigation, in my	me, date and place	ce, and due to the curred at the time	e cause(s) and mann e, date and place, and	er as stated. I due to the cause(s)
	To the To the complet	Me	29b. Signature and title of certifier	-(()		29c. Licens	se number		29d. Date signed (M	Month, Day, Year)
			Monly	F	du	1487	81365	5	September	6,2008
			30. Name and address of person who completed ca	use of death (Ite	m 23a) (Type					
ı	Sta	te	31. Date filed (Month, Day, Year) 32.	gistrar's Signa	atur	Innale!	PAIT	inore,	MD 212	<u> </u>

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1008

		For	State of Maryland / De	partment of	Health and	Mental Hygie	ene2008	30195
		State Registrar		ertificate of	Death		J. No.	2 Time of Dooth
• Physician		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	
/Medical Examiner	1 -	Kathryn Elizabe ta. Facility Name (If not institution, give s		4b. City, Town,	or Location of Deat	September	7 200 4c. County of De	
		Julia Manor Nurs			gerstown		Was	hington
Funeral		5. Social Security Number 6. Sex	M 2 XF 7. Age (In yrs. last birtho	Months Days		(Month, Day, )		rthplace (State or Foreign country)
Director		220-10-3181 Usual Residence of Decedent	89	*		April 22,	1919   M	aryland
death with the Maryland ms 23e or 28a-f show rinust be notified at		10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
Ba-fs	2	Maryland Washi	ngton W	illiamspor	·+			1 ☐ Yes 2 🔀 No
vith th	runeral Director	10e. Street and Number		10f. Zip Code		109	g. Citizen of What C	Country?
s 23s	0	10524 Peach Tree		13 Was Decedent of	21795 Hispanic Origin? (S	specify Yes or No-	USA 14. Race - Arr	nerican Indian.
fler d	5	11. Marital Status  1 ☐ Never Married 2 ☐ Married	1 □Yes 2 No	13. Was Decedent of If Yes, specify Cub		to Rican, etc.)	Black, Wh	
nit. Pages I and 2 should be filed within 72 hours after death with the Marylan and Mental Hygiens attended to Health and Mental Hygiens attended to that than "natural", or flems 23s or 28s-f show ortant: if then 27 is marked othar than "natural", or flems 23s or 28s-f show injury or othar traumatic event, the Medical Extra or must be notified at injury or othar traumatic event, the Medical Extra or The Ref. Commission by Europea Director	à	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No	Specify:		Specify:	White
72 hc	Completed by	15. Decedent's Educ (Specify only highest grade	completed) (C	ecedent's Usual Occu	during most of wo	rking 16	6b. Kind of Busines	s/Industry
within iene.	Ē.	Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use retire				
filed Hygie Hygie other family and family fa		11 17. Father's Name (First, Middle, Last)		Housewi		me (First, Middle, Ma	HOI aiden Sumame)	me
d 2 should be file th and Mental Hy t7 is marked oth traumatic event	o ne	James Samuel Cro	ckett. Sr.		Blanche	e Belle	Busick	
shou and M and M and M		19a. Informant's Name/Relationship (Typ		lailing Address (Stree				Zip Code)
and 2 salth a n 27 ls ar tra		Bradley S. Crocket	t-Nephew 29	73 Oakbord	ough Squar	e üaktor	, Virgin	ia 22124
of He of He or oth	ij	20a. Method of Disposition  XXBurial 2 □ Cremation 3 □R	20b. Place of D cemetery,	isposition (Name of crematory or other pla	асе)	Date 20	Oc. Location - City of	or Town, State
Pag ment tant:	1	'4 □ Donation 5 □ Other (Specify)	Rose Hi	II Cemeter			gerstown	, Maryland
permit. Pages 1 a Department of Hea Important: If Item any injury or otha once.		21. Signiture Funeral Funeral License		Osborne Pu		,		
402 8 d	+	220 Part Spire to disease or compli						+, MD 21795
Physician		23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final	e cause on thich line.	411 P	1/00/11	'8m		Onset and Death
/Medical	-	disease or condition resulting in death)	Due to (or as a consequence of)	cy co	ENC C			1 == 1 (
Examiner	4	Sequentially list conditions	USPIER	Heco		,		Motant
P = 2	Je l	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of)		Da ma	TILIO		Voeno
and I-trans	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence of)	LS &	10-10 02-	ma		1000
te be executed ysician and te burial-transit	Ea		(1/3/a)	) Li	10000	Ketter	2	years
# 25 E	_	0						
death certifica e attending ph d for use as th	2	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregnancy 1□Live birth 2□Fetal death	2 Destania aragnan	014		23d. Date of d	
0 0 0	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death	3 ☐Ectopic pregnant 5 ☐ Other (specify)			Month	Day Year
at the	Z Z	9 Unknown				an Diduk		4- 45- 4
requires that the een signed by the hould be detache		Part II. Other significant conditions con	tributing to death but not resulting in the	ne underlying cause g	iven in Part I.			to the cause of death?  Probably 4   Unknown
v requir	Completed		701					
sician: The law requires to certificate has been signe irector, page 2 should be	E E	H	110	100.		24a. Was an autopsy perform	prior to	autopsy findings available o completion of cause of ?
ician: The li certificate ha rector, page	2	OF Man area referred to modical	118 agrae			1 ☐ Yes 2	1 □ Yı	as 2 No
	מ	25. Was case referred to medical examiner?  1 Yes 2 700	ospital: 1 Inpatient 2 ER/Outp.	ationt 30 DOA		ath <i>(Check only one</i> Home 5 ☐ Resider		necify)
ding Phys h. After this funeral di	0	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Inju		28d. Describe how		
Attanding Frideath.	Certification:	1 Natural 5 Pending 2 Accident investigation	(WOMI, Day 1 ear)		Yes 2 No			
l or Attanding Phy after death. Director: After this I in by the funeral d		3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	•	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
spital or Attan ours after deat leral Director: filled in by the	2	22- 2-4-1	inter-F-M-1 - 1 - 1 - 1	d			100/01/01/01	as stated
To the Hospital or Attantwithin 24 hours after death To the Funeral Director: completely filled in by the	edical		ician: To the best of my knowledge, oner: On the basis of examination and/ and manner stated.					
To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	ALL III SIGNOV.	29c. Licer	nse number	29	d. Date signed (Mo	nth, Day, Year)
1350		1 Ville	- gum.n	2	04503	7 . 3	STEPT O	07,2008
A	-	30. Name and address of person who co	mpleted cause of death (Item 23a)	(pe, Print)	111	Howe		Hap MD21
V		SHAHAB 2 SO	sprace 19	414 C	Ce Ce	vong	The ?	reg VILISI
State Registra		31. Date filed (Month, Day, Year)	82. Registrar's Signature	hearts!				U

			For State	State of	Marylan					and M	ental Hy	_	2002	30196
			Registrar  1. Decedent's Name (First, Middle, Last	)		Cer	tificate	סז ט	eatn		2. Date of De	Reg. No	.2000	3. Time of Death
	Physici /Medic		WARREN	,	SM	ITH					Month SEPTEM	Da	2, Year 2008	2205 M
	Examin		4a. Facility Name (If not institution, give		nber)		4b. City, To	own, or L	ocation o				. County of Death	
	a na Maria an Maria na an Andrea an Angala an	H	PRINCE GEORGE HOS  5. Social Security Number 6. Se		7 Ann (In	last hirthday)	CHEVE		If Under 2	DA Hrs	8. Date of Bi		RINCE GI	
	Funeral Director			XM 2□F	7. Age <i>(In yrs.)</i> 41	Yrs.			Hours	Min.	(Month, Da 09-29-	ay, Year,	)   Cot	nplace (State or Foreign Intry) HINGTON DC
	0		Usual Residence of Decedent			y, Town or Lo							77222	
	//anyla f shov ed at	or	10a. State 10b. County PRINCE GE	ORGE		DOVER	cation							10d. Inside City Limits 1     Yes 2   No
	r 28a- notifi	irect	10e. Street and Number				10f. Zip C	Code				10g. Ci	tizen of What Cou	untry?
	ath with	ral D	7629 ALLENDALE CIR	CLE			2078	5					U.S.A.	
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	y Funeral Director	11. Marital Status  12 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 <b>X</b> □ No e		Vas Deceder f Yes, specify I □ Yes 🎇	y Cuban,	panic Orio Mexican Specify:	gin? (Spec i, Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - Amer Black, White Specify:	
9	2 hour aturai cai Ex	Completed by	15. Decedent's Edu	cation	ites.	16a. Deced	lent's Usual	Occupati	ion			16b. K	Ind of Business/I	
215	ithin 7, ne. nan "n	nple	(Specify only highest grade	e completed) College (1	-4or 5+)		kind of work OO NOT use		ring most	of workin	g			
2	illed w Hygier ther th		12TH  17. Father's Name (First, Middle, Last)			CAI	RPENTE		8 Mothe	r's Name	(First, Middle		VATE	
au	be d c	To Be	LONNIE W. SMITH J	R.				1			ENCER	,	, , , , , , , , , , , , , , , , , , , ,	
Maryland 21215-0036	a s a		19a. Informant's Name/Relationship (7)	rpe. Print)		19b. Mailin	g Address (5	Street an	d Numbe	r or Rurai	Route Numb	er, City	or Town, State, Z	ip Code)
	1 and 1 Health tem 27		ELIZABETH SMITH/SI 20a. Method of Disposition	STER	20b B	1911 1			N DR		3 LAND		MD 207	
altimore,			1⊠ Burial 2 ☐ Cremation 3 ☐ F		State C	emetery, cren	natory or oth	er place)					TON, MD	Town, State
altir	permit. Page Department of Important: if any injury or once.	H	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens		F-22								NERAL HO	RE
ñ	Im any	0 0	K-D. Y-h	24		74	474 LA	NDOV	ER R	D LA	NDOVER	, MD	20785	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	END Due to (	STAGE I	RENAL I	DISEAS		such as	cardiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Duste (	ETTES MI or as a consequence ETTENSIC or as a consequence	uanda olij: ON	i							
P.O. Box 6	death certifi e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  Part II. Other significant conditions co	1 ☐ Live b 4 ☐ Pregn 9 ☐ Unkno		Ideath 3□ eath 5□	Ectopic preg	cify)	in Part I		23a Did	tohacco	23d. Date of deli	very Day Year the cause of death?
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Vital Records,	sIcian: The law requires that the certificate has been signed by the irector, page 2 should be detache	Completed										psy ormed?	prior to c death?	topsy findings available ompletion of cause of
ıtal		BeC	25. Was case referred to medical examiner?					2	26. Place	of Death	1□ Yes (Check only	2 No one)	o 1 ☐Yes	2, <b>4</b> NO
	Physical this car	2	1 ☐ Yes 2月 No	_		ER/Outpatien			4 □ Nu				6 □Other (Spec	eify)
O	nding h. h. After funer	tion:	27. Manner of Death  1   Natural 5   Pending investigation	28a. Date of (Mont	h, Day Year)	28b. Time of Injury	_ M 280	c. Injury a Work? 1 □ Ye	at es 2 <b>X</b> il		8d. Describe	how inju	iry occurred	
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification properties in by the funeral director, completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildin	of injury - At ho ng, etc. <i>(Specif</i> )	ome, farm, stre					8f. Location ( City or To	Street a wn, Stat	nd Number or Ru e)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b	Medical (	29a. Certifier (Check only one) CertifyIng Phy 2 Medical Exam	sician: To the ner: On the ba and mann	isis of examina	wledge, death tion and/or in	occurred at vestigation, in	t the time n my opi	, date an nion, dea	d place, a th occurre	nd due to the	cause(s	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier				29c. L	License r		2162	7	29d Da	ate signed (Month	n, Day, Year)
<u> </u>								L	105	318	4	1/1	1/08	
2	(3)		30. Name and address of person who of C. DONALD GEORGE				,	EDT V	N/T	2076	25			
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa		COLLEVI	LIVLI	, FID	2078	) )			
	Registr	ar	SEP 0 8 2003		K L	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September D Day 12:29 AM 1,2008 ANTHONY GARTRELL SMITH 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) WASHINGTON HAGERSTOWN WASHINGTON COUNTY HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign March 14, 1958 WASHINGTON, DC Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F 50 229-92**-**8143 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2√ No KEEDYSVILLE MARYLAND WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21756 U.S.A. 19239 BURNSIDE BRIDGE ROAD 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2**X** No Specify Specify: WHITE 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAR SALESMAN AUTO DEALER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) IDA M. GARTRELL GERALD L. SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARPERS FERRY, WV WRENS VIEW LANE, LINDA MCDONOUGH, SISTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/10/2008 STAUFFER CREMATORY FREDERICK, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Fineral Fervice Licensee 21713 7606 Old National Pike, Boonsboro, MD Part 1. Inter the disease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by leart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part 1 Immediate Cause (Final disease or condition resulting in death) Cuncer YEWS (olon Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseas or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 □Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

,00

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, the Mones.

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

physician and s the burial-trans attending p for use as t

certificate this c After thi funeral of

Examiner Physician/Medical Completed by Be Certification: To

Medical

the Hospitai or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760, To the Hospina. within 24 hours after death.
To the Funeral Director: After a To the Funeral Director. After a To the Funeral Director.

> 31. Date filed (Month, Day, Year) State SEP 1 0 2008 Registrar

29b. Signature and title of certifier

nichae (

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide



1 Inpatient

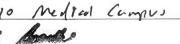
28a. Date of Injury (Month, Day, Year)

Hospital:

5 ☐ Pending investigation

6 ☐ Could not be

determined



2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

41667

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year DRRAINE SUMMERS 0030 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Chesapeake Hospice House Harwood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/24/1920 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M Illimois 379-12-7199 87 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director North Carolina Halifax Littleton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 137 Sharon Lane 27850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 □ No If Yes, Give Year or Dates: 1943- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Specify: White 1943-44 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Agent Realtv Department of Health and Mental Hygie Important; If Item 27 is marked other any injury or other traumatic event, It once, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David O'Donohue, Sr. Ruth Carlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Virginia A. Passaro/Daughter 121 Bay Drive, Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Kalas Crematory 08/30/2008 Edgewater, Maryland Nyice Lifensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral § 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) leen **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-tra Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknow signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 has autopsy лп**ее**? 2**Д** No certificate Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 AOther (Spec 1 ☐ Yes 2 No Hospice House 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural
2 Accident Iniury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

ospital or Attending I within 24 hours after death To the Funeral Director: Hospital Medical completely To the I

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

that the death certificate be executed

Box 68760

P.0.

Division or Vital Records,

Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Name and address of person v

completed cause of death (Item 23a) (Type, Print)
ENTH WY YYF DEYENSE HAHWAY ANNAPOUS MAZIYUI 31. Date filed (Month, Day, Year)

08-06958	
Bobby Sturgill	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death Reg. No. 2008 3019
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year
<b>)</b>	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4c. County of Death Baltimore
Funeral Director	5. Social Security Number 213-68-2946  6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Months Days Hours Min. NOV 28, 1954 Maryland
w any.	Usual Residence of Decedent  10a. State
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show numatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Maryland   Cecil   Elkton   106. Street and Number   106. Zip Code   109. Citizen of What Country?   1740 Singerly Road   21921   United States
s after death with ran", or items 23 timer must be no by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced of Pates:  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify:
5-0036 led within 72 hours stygiene. other than "natur the Medical Exam Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Carpenter  Carpenter  16b. Kind of Business/Industry  Construction
21215-0036 ould be filed within 7 the Mental Hygiene is marked other than its event, the Medical To Be Comple	17. Father's Name (First, Middle, Last)  Emory E. Sturgill Roark  19a. Informant's Name/Relationship (Type, Print )  18. Mother's Name (First, Middle, Maiden Surname)  Edna Eller  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Complet	Helen F. Sturgill/Sister-In-Law 1740 Singerly Road, Elkton, MD 21921  20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  September 20c. Location - City or Town, State
Baltimo permit Pag Department Important: injury or of	21. Signature of Funeral Service Licensee    R. A. Ferris & Co., Inc.   16, 2008   West Chester, PA
Physician /Medical *xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death  Death
led nsit <b>Examiner</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):
execul an and al - tra	Xunpended 23a,27,28a-f, permE, g888 2/18/09 TT
Box 6876: e death certificate the attending phy ed for use as the I hysician/IM	225. If yes, obtaine of pregnant y  226. If yes, obtaine of pregnant y  1
ires that the designed by the signed by the sible detached for the by Physical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 V Unknown
cords aw requires been 2 should	24a. Was an autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
f Vital Rec Physician: The I er this certificate I ral director, page To Be Com	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other, Nursing Home 5 Residence 6 Other:
- # - < #   b	1 Natural 5 Pending Investigation Pending In
C of an an an	4 Homicide (Specify) FALISCOII, FID
To the Ho within 24 To the Fu completel	29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  September 15, 2008
	35. Name and address of person who completed douse of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland / Dep	artment of Health and ertificate of Death	Mental Hygier	- 7 11110 0117111
Si			Decedent's Name (First, Middle, Last	)		2. Date of Death Month	Day Year 3. Time of Death
	Physici		Collie U.	Teague		SEPTENB	EK 2,2008 6:05 PM
الم	/Medic	4	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Death
	Examin	er	Doctor's Hospita		Lanham		Prince George's
		- 48	5. Social Security Number 6. Se		1 1111 1 0411	s. 8. Date of Birth	Birthplace (State or Foreign
	Funeral		10	M 2 □XF 72 Yrs.	Months Days Hours Mir	Month, Day, Ye. August 12	
- '2	Director		224-44-9773 Usual Residence of Decedent	12		August 12	, 1950 VIIginia
	pug *		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	sho sho ad at	'n					1 ☑ Yes 2 ☐ No
	Ba-f	ctc	Maryland   Prince G	eorge's Bowie	10f. Zip Code	100	Citizen of What Country?
	or 2	Director	10e. Street and Number	-			
	23a ust l		1803 Foxwood Circ		20720		nited States  14. Race - American Indian,
	be filed within 72 hours after death with the Maryland ntal Hygiene.	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	Specify Yes of No- erto Rican, etc.)	Black, White, etc.
9	or It		1 ☐ Never Married 2 ☐ Married	1  Yes 2 XNo	1 ☐ Yes 2 🔀 No Specify:		Specify: African
3	ral",	Completed by	3 XWidowed 4 ☐ Divorced	Year or Dates:			American
ਨ੍ਹ	2 hc	tec	15. Decedent's Edu (Specify only highest grad	te completed) (Giv	edent's Usual Occupation re kind of work done during most of w		b. Kind of Business/Industry
Ž	hin an "r	힐	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		
7	d wit	Į.		2 years Reg	istered Nurse		Private
ō	i Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, Mai	den Surname)
a	d be ental ked o	To B	Matthew Urguhart		Grac	ie Joyner	
Baltimore, Maryland 21215-0036	2 should be and Mental seamarked or raumatic ev	-	19a. Informant's Name/Relationship (7	ype. Print) 19b. Ma	ling Address (Street and Number or	Rural Route Number, C	ity or Town, State, Zip Code)
Z Z	d 2 s th ar 7 is trau		Richetta Webb -	Daughter 430	1 Holmehurst Way	West Bowie	, MD 20720
a)	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any Injury or other traumatic once.		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)	Date 20d	c. Location - City or Town, State
Ö	ges If life or or		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		- 0 2000	A1 77 A
Ξ	Pa men ant: ury		4☐Donation 5☐Other (Specify	A	Nat'l Cemt. Sep		Arlington, VA
ᇷ	Depart Depart Import any Inj once.		21. Si hature of Fore al Service Licen	The Man	22. Name and Address of Facility		-
00	S E E S		W. L. D. M. M.	- HARWAR	4001 Benning Roa		
1-	-		23a. Part 1 Enter the disease, or comp	olications that caused the death. Do not eone cause on each line.	nter the mode of dying, such as card	iac or respiratory arrest	Approximate Interval Between
	Physician		Immediate Cause (Final	MON - SMALL C	ELL LUNG C	ANCER	Onset and Death
2	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence of):	E	IVCK	
`	Examiner			BRAIN METAS	TASIS		
		<u></u>	Sequentially list conditions,	b. Due to (or as a consequence of):	7/0 10		
	o	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0) 00 0 00 00 00 00 00 00 00 00 00 00 00			
	ecut and -tran	Exami	that initiated events resulting in death) Last	c Due to (or as a consequence of):			
Ö,	e ex	E	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a consequence or).			
8760,	icate be executed physician and s the burial-trans t	dical		d			
9	tifica ng ph as tl	Med	IE EELAN E				
Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death	B Ectopic pregnancy		23d. Date of delivery
0	death atte	Cia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of death	Other (specify)		Month Day Year
P. O.	the cy the chec	İŞ	9 □Unknown	9□Unknown			
	The law requires that the death certificate be executed as been signed by the attending physician and page 2 should be detached for use as the burial-trans		Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
g	ires sign	by				1 ☑ Yes	2 No 3 Probably 4 Unknown
0	w require been sign	Completed				_	Odi. 186
ec	hasb ye2sh	를				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Œ	The late has page	LO.				performe 1∐ Yes 21s	death? ☑No 1 ☐ Yes 2 ☐ No
Vital Records,		BeC	25. Was case referred to medical		26. Place of	Death (Check only one)	
>	Physician: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpat	ient 3 DOA Other: 4 Nursin	g Home 5 Residence	ce 6 Other (Specify)
0	T 20		27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how	
on	ding F h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Day Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No		
Division	I or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not be		street, factory, office	28f. Location (Stre	et and Number or Rural Route Number,
2	or Al	ŧ	4 ☐ Homicide determined	building, etc. (Specify)	, ,,	City or Town,	State)
	To the Hospital or Attenwithin 24 hours after death Within 24 hours after death To the Funeral Director:			- Indian To the heat of an income in the	noth convered at the time, date and a	lace, and due to the seri	lea(e) and manner as stated
	t hot tune	cal	(Check only 2 Medical Exar	ysician: To the best of my knowledge, deniner: On the basis of examination and/o	east occurred at the time, date and p r investigation, in my opinion, death o	occurred at the time, dat	e and place, and due to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)	and manner stated.			
	To t To t	Σ	29b. Signature and title of certifier	, ) /	29c. License number	290	d. Date signed (Month, Day, Year)
			MICHAN	tolling, MD	D43162		9/3/08
	80		30. Name and address of person wh	completed cause of death (Item 23a) (Type	pe, Print)		
V_	(5)		MEWIN GASKINS	MD 7831 BELLE 1	OINT DR. GREEN	BED . MO	20770
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		- 1	
	S	tate	0 0 2000	Le Lacks	-		

08-06729 Anthony Velez Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

nony velez	1	For State 1 1/40 THE ROLLD CC Certifi	icate of	Death 09	/08/0	18 Re	eg. No. 20	08 3020
Physicia		l-For State Registrar Amended#8perFH FCHD SG Certiff 1. Decedent's Name (First, Middle,Last)		03	770070	<ol><li>Date of Deat</li></ol>	h	3. Time of Death 2110 hrs
dical Exami	ner	ANTHONY VELE				Month Septembe	r 2, 2008 4c. County of De	
		4a. Facility Name (if not institution, give street and number) 7958 Parkland Place	4	b. City, Town, or Frederick	Location of	Death	Frederick	
		5. Social Security Number 6. Sex 7. Age (In yrs. last I	birthday)	If Under 1 Year	r If Under	24Hrs. 8. Date of Bir	th(MM/DD/YYYY) g.	Birthplace (State or
Funeral Director		V	49 Yrs.	Months Days	Hours	Min. Sept.	10, 1950 <sup>Fol</sup>	Country) New York
	-	Usual Residence of Decedent	47			bepe:	10, ->	
any	ı	10a. State 10b. County 10c. City, To	wn or Location	on				10d. Inside City Limits  1 Yes 2 No
ind show nce.	5	Maryland Frederick Fred	erick				0g. Citizen of What C	ZL
Maryla 28a-f d at o	Directo	10e. Street and Number		10f. Zip Code	701		U.S.A	
rith the Maryland 5 23a or 28a-f show s 1 notified at once.		7958 Parkland Place	Tao Ma		701	n? ( Specify Yes or No		merican Indian, Black,
th wit tems 2	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Ye	es, specify Cubar	n, Mexican,	Puerto Rican, etc.)	White, etc	
er dea	Ē	3 Widowed 4 Divorced If Yes, Give Year	1X	Yes 2 No	specifyP	uerto Rica		White
urs afi itural' amino	d by	15. Decedent's Education (Specify only highest grade completed)	6a. Deceden	t's Usual Occupa	tion (Give k	ind of work done use retired)	16b. Kind of Busine	ss/Industry
6 72 hc an "ng cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	damig	Unemplo		,	N/A	
003 within iene.	ᇤ	12 17. Father's Name (First, Middle, Last)		OHEMPIO		s Name (First, Middle,		
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	o l	Frank J. Velez				D. Vilche		
212 212 Muld be Menti mark	O B	19a. Informant's Name/Relationship (Type, Print )					mber, City or Town, S	
MD nd 2 sho alth and m 27 is		Diana Legler / Sister				, Ft. Morg	an, CO 80	/UI ty or Town, State
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		2021 Motivos de Stoppestato 2 Romoval from State cre	matory or ot					
Page Page nent o		4 Donation 5 Other Specify: Sm1		rg Crema				rg, Maryland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21 Signature Funeral Service LC (188)					NERAL HOMI	ES, P.A.
Physician	(	23a. Part I. Enter the disease, or complications that gaused he death. D	00 not enter t	NORTH he mode of dying	MARK g, such as ca	ardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
Medical		failure. List only one cause on each line.						Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Attrefoscier  Due to (or as a consequence of):						
	Ļ	Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause						
b. de	Xar	events resulting in death) Last Due to (or as a consequence of).						
executed an and II - transit		d.  UNPENDED AMENDED						
60, ate be ex ohysician ne burial	Medical	IF FEMALE: 23c. If yes, outcome of pregna	ancy				23d. Date of de	· ·
OX 687 eath certific	sician/		=		Ectopi	c pregnancy	Month	Day Year
Box 687  death certific  the attending ped for use as the	ysic	1 Yes 2 No 9 Unknown g Unknown	. 5 0	ther (Specify)				
O. Be nat the deed by the etached for	Phy	Part II. Other significant conditions contributing to death but not res	sulting in the	underlying cause	e given in Pa			ute to the cause of death?  Probably 4 ✓ Unknown
, P.C res that signed 1 be deta	d by	Chronic alcohol abuse	<u> </u>			24a. Wa		ere autopsy findings available
rds v requi s been should	se					au	topsy pri	or to completion of cause of ath?
Records, The law requir ficate has been s	Completed							Yes 2 No
n of Vital Recling Physician: The land	BeC	25. Was case referred to medical			of Death	(Check only one)  Nursing Home 5	Residence 6	Other: Scene
of Vital ng Physician After this certi	0	1 ✓ Yes 2 No	ER/Outpatier 28b. Time of		njury at Wor		ne how injury occurred	
n of oding Plan. h. shere	=			' ' I	Yes 2	_		
Division tal or Attendirs after death.	Eat	2 Accident Investigation 28e. Place of Injury - At hor	me, farm, str	eet, factory, office	e building, 6		n (Street and Number	or Rural Route Number, City
Division pital or Attent ours after death leral Director: filled in hy the	Certification:	3 Suicide 6 Could not be determined (Specify)						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Purneral Director: After this certificate has been signed by the attending physician and commissive filled in whe fineral director, page 2 should be detached for use as the burial - trans			e, death occ	urred at the time,	date and p	lace, and due to the concrete at the time.	ause(s) and manner a ate and place, and du	e to the cause(s)
To the Hos within 24 h To the Fun	edical	and manner stated.	id/or investig		ense numbe			d (Month, Day, Year)
	Σ	29b. Signature and title of certifier			C.M.E.		September	3, 2008
-4	V	30. Name and address of person who completed cause of death (Item:	23a)					
18)	4	Patricia Aronica-Pollak MD. Assistant Medical E	xaminer	111 Penn	Street, B	altimore, MD 21	201	
	State		re A	ade v				
Regi	stra	SEP 0 5 2008 Stewn A	6110	A1				
DHMH 17 Rev 1	/2001	DOME	ORÏGIN	AL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harlen Claire Wampole 12:55 September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Vindobona Nursing Center Frederick Braddock 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours Min 1 M M 2 □ F 83 399-16-2081 Yrs. Wisconsin Director October 10, 1924 Usual Residence of Decedent 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 990 Waterford Drive 21702 United States "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1947-13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iten 1 ☐ Never Married 2 X Married 1 ☐Yes 2 No Specify White δ Specify: 3 Widowed 4 Divorced 1950 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) 8 Relay Operator Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claudia M. Hays John J. Wampole ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau 145 Roxbury Road, Newville, Pennsylvania 17241 Claudia Moxley / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Frederick, Maryland 17, 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cruse on each line. Immediate Cause (Final **Physician** ascenomu. disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of burial-trai Due to (or as a consequence of) physician s the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 2 □No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Accident 1 ☐ Yes 2 🗆 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed Division of Vital Records, certificate or Attending Physician: this thours after death.

uneral Director: Af ely filled in by the ful Within 24 hours and.
To the Funeral Direct To the Hospital

with the Maryland

death

Baltimore, Maryland 21215-0036

P.O. Box 68760,

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who com

Robert L. Kaufmann, M.D.

(Check only one)

9 2008

RI



cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

29c. License number

300 West Ninth Street, Frederick, Maryland 21701-4541

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan				lental Hy	giene			
			1 - State Registrar		Cer	rtificate of D	eath	Reg. No. 2008 30203				
-3	Physici	an	Decedent's Name (First, Middle,     Charles Rudolp	,				2. Date of Death Month September 3,2008 7:32 A.				
	/Medio		4a. Facility Name (If not institution,			4b. City, Town, or L	ocation of Death	Depeteria		y of Death	7.02 210	
A		CI		Hospital Center	r	Cheve	erly		Princ			
	Funeral Director	8	5. Social Security Number 578–56–5667	3. Sex 7. Age (In yrs. 1 66	last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 05/06/	h v, Year) 1942	Cour	place (State or Foreign attry)  D.C.	
	w w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits	
	Maryl-f sho	to		.G. (	Capito	l Heights					1 KgYes 2 □ No	
	r 28a	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	23a c		1400 Dunbar C	aks Drive		2074				.S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 🏻 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Bla	ace - Americ ack, White, Af: ify: Ame:	etc. rican—	
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21	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. i	DO NOT use retired) eral Suppl		9	U.S. G	_		
2	filed w Hygiel ther th		17. Father's Name (First, Middle, Li	ast)	Gerr		8. Mother's Nam	e (First, Middle,			illeric	
Maryland	lid be lental lental ked o	To Be	Arthur Wilso	•			Annie F	ranks				
ary	2 shou and N is mar	-	19a. Informant's Name/Relationshi			ng Address (Street an				_		
Σ,	and 2 lealth m 27 her tra		Charles R. Wilso	·		Dunbar Oa		Capitol Date	Height 20c. Location			
Baltimore,	ages 1 nt of H : If ite		20a. Method of Disposition 1 → Burial 2 □ Cremation	3 ⊔Hemovar from State		osition (Name of matory or other place)						
Ιξίπ	artmer artmer ortant injury		4 □ Donation 5 □ Other (Special Service L)			Mem. Cem.  2. Name and Address	09/1				Maryland	
Ba	permii Depar Impor any ir once.		Dany N	Cratt	4	2. Name and Address H.S.Wash 925 Burrou	nington Ighs Ave	& Sons ( .,N.E.,1	Co.,Inc Washing	ton,D	.C. 20019	
4.			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused the deat nly one cause on each line.							Approximate Interval Between Onset and Death	
ą	Physician		Immediate Cause (Final disease or condition	_a. Nex	2ne	>					Onset and Death	
1	/Medical Examiner		resulting in death)	Due to (or as a or nseq	uence of):		555					
1	F4 F48	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):	nni	~					
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· Carrer	ron	na Ti	ma	ne				
Ö,	ate be executed hysician and the burial-transit	Ex	resulting in death) Last	Due to (or as a conseq	uence of):					-		
8760,	icate b physic s the b	dical		d					<u> </u>	-		
9 xc	leath certific attending p I for use as i	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna					23d. E	ate of deliv	very	
. Box	death certific e attending p id for use as	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		⊒Ectopic pregnancy ⊒ Other (specify)			Month Day Year			
P.0	at the by the	hys	9 Unknown	9∐Unknown			1.5	OO. Did			the east of death?	
	w requires that the de been signed by the s should be detached	by	Part II. Other significant condition	is contributing to death but not res	ulting in the u	nderlying cause giver	n in Part I.				the cause of death?	
or Vital Records,	v requ	Completed						24a. Was	an 241	o. Were aut	opsy findings available	
Re	e la has	duc						auto	psy ormed?	prior to co death?	ompletion of cause of 2 □ No	
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r V	Physician; this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Other	<sup>r:</sup> 4 □ Nursing H	ome 5□Res	idence 6 🗆 C	ther (Spec	ify)	
	ing Pl		27. Man or of Death 1 ★ Natural 5 ☐ Pending		28b. Time o Injury	Work		28d. Describe	how injury occ	urred		
Division	Attending r death. ector: After y the fune	icati	3 Suicide 6 Could no	ot be 28e Place of injury. At h	ome, farm, st		es 2 □No	28f. Location (	Street and Nu	mber or Rui	ral Route Number,	
<u>S</u>	ai or A s after il Dire	Certification:	4 ☐ Homicide determin	building, etc. (Special	fy)	,,		City or To	wn, State)			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical C		Physician: To the best of my knot examiner: On the basis of examina and manner stated.								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	47		29c. License	number		29d. Date sig	ned (Month	, Day, Year)	
			1/ fre	er-	MI	00:	303/	8	9/	3/0	8	
)	(5)		30. Name and address of person y	who completed cause of death (fter	n 23a) (Type,	Print)	10	Maria	1/2	mr	20185	
		ata.	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ature	DATINE	DK (	INVL	114	1110	00180	
27	St Regist	ate rar	SEP 0 8 2008	Kenny & A	book	/			•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ε. Williams, Jr. <u>Clarence</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner rince ever If Under 1 Year | If Jonder 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 □ F Hours Director March 20, 1930 Washington, DC 578-36-6202 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 'natural", or items 23a or 28a-f shood and Example of the state of the 1 √2 Yes 2 No Director District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20002 310 - 12th Street, United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐Yes 2 ☐X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify à Specify: Black 3 ☐ Widowed 4 P Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within than than Mental Hygiene.
7 is marked other than " other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) <u>Government</u> 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence E. Williams, Sr. Helen Hawkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1206 Rosedale Court Hyattsville, MD 20782 of Health Michelle Cottom - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Sept. 6, 2008 Washington, DC 4 Donation 5 ☐ Other (Specify) 21. Synature of Funeral S-rvice Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate use (Final Approximate Interval Between Onset and Death ATRELOSC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events due to für as a consequence of) Examir The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for in the past 12 months? signed by the ard be detached for 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □ Yes 2. No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊿Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day,

SEP 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State of M	aryland / Do	epar C <i>er</i> ti	tment of ificate o	Health f Deat	and M h	1ental H	lygien Reg. Ne		3020							
Physician /Medical	1	Decedent's Name (First, Middle, Last)	Walter I	eroy Wel	ty				2. Date of Month Septe	Da	<sup>ay</sup> 7, 2008	3. Time of Death 6:46 P M							
Examiner		Washington County 5. Social Security Number 6. Sep	Hospita 7. Ag		day)_	Hager	s town	er 24 Hrs.	8. Date of	1	washingt	On							
Director		232-26-7407  Usual Residence of Decedent  10a. State 10b. County	M 2□F	86 Yı	rs.	Months Day	s Hours	s Min.	8. Date of (Month, June	8, 19	922 Wes	t Virginia  10d. Inside City Limits							
with the Maryla to 128s-1 show the notified at		WV Jefferso  10e. Street and Number	n	Harpers		10f. Zip Code				10g. C	1 ☐ Yes 2 ☒ No								
1Z 1 5-UU30 within 72 hours after death with the Maryland ane. than "naturat", or items 23s or 28s-1 ehow ite Medical Examinat must be notified at ampleted by Funeral Director	a la la la la la la la la la la la la la	619 Halltown Roa  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:			254: as Decedent of res, specify Co	Hispanic ( Joan, Mexic		ecify Yes or Rican, etc.)	No-	USA  14. Race - American Black, White Specify: Wh								
Z I Z I D-UUSO ed within 72 hours all ygiene. ner than "natural", or ner than "natural", or it, the Madical Exemi Completed by F	nanaldino	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12)	cation	5+)	Give ki	nt's Usual Occ nd of work dor NOT use reti	e durina m	ost of work	ing		Kind of Business/								
Maryland d 2 should be file th and Mental Hyg 27 is marked othe traumatic event,	0	17. Father's Name (First, Middle, Last)  John Adam Welty.	Sr.			10 981.1			e (First, Midd lanche	dle, Maide	n Sumame)								
it. Pages 1 arrithment of Heal		19a. Informant's Name/Relationship (Ty  Wayne Welty - Nep 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensis	hew	73 20b. Place of D cemetery,	We Disposit Crema	1ty Hi	11 - <sub>(ace)</sub> em.	Harpe 9/1	rs Fer <sub>Date</sub> 1/08	ery, l	or Town, State, 2 WV 25425 Location - City or and Shung	Town, State							
Physician /Medical Examiner	<u> </u>	23a. Part1. Enter the disease, or complete shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	M970 d the death. Do no no. a consequence of	ot enter C	me - H the mode of d	ying, such	s Fer as cardiac	ry, WV or respirator	254		Approximate Interval Between Onset and Death							
cate be physicie the but the but dical	by Physician/Medical Ex	by Friysiciarymedical Ex	מונשו בא	dicai Ex	dicai Ex		מונשו בא		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome	2 Fetal death	3 □E	ctopic pregnar					23d. Date of deli	very Day Year
S B B S			9 Unknown Part II. Other significant conditions cor		out not resulting in t	the und	erlying cause	given in Pa	rt I.	11	□ Yes 2	2 No 3 Pr							
									24a. W at pe 1  Ye	utopsy erformed?	prior to death?	topsy findings available completion of cause of 2 No							
ding Phys I. After this funeral dii	0 2	25. Was case referred to medical examiner?  ★Yes 2 No  27. Manner of Death  ★SNatural 5 Pending 2 Accident investigation	ospital: 1  Inpati 28a. Date of Inju (Month, Da	ury 28b. Tir	ne of	28c. In	other: 4 🗆	Nursing Ho		esidence	6  ☐Other (Specury occurred	sify)							
To the Hospital or Attending P Within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						n (Street a Town, Sta		iral Route Number,								
To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by Medical Certif	3	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exemi	sician: To the best ner: On the basis of and manner st	f examination and/	death o	stigation, in m	opinion, d	leath occur	and due to t red at the tim	ne, date ar	nd place, and due	to the cause(s)							
with To 1		29b. Signature and title of certifier  20b. Na an addr as of person who co	mpleted cause of	death (Item 23a) /T	vpa. Pr	Po	nse numbe			_	ate signed (Monti								
3H-4 State		Stephen Kotch, p. 31. Date filed (Month, Day, Year) SEP 1 0 20	32. Registr	Z. A-t.c		•	Hag.	stou	-, M	) 2	21740								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 30, 2008 ear 11:54 AM **Physician** Ward. Sr. Douglas Kenneth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Owings Street 1975 5th If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 7, 1944 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** 1 ▼ M 2 □ F Maryland 64 216-44-7272 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Calvert Owings Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20736 1975 5th Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: white Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) marina dock master 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marquess Isabel Gertrude Ward ၉ Gilbert Lacv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5th Street, Owings, MD 20736 Chalice O. Ward, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ↑ Metropolitan Crematory 09/05/08 | Alexandria, VA 21. Signature of Funeral Service Ligens 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 elber 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Anomi disease or condition resulting in death) /Medical Due to (or as a consequence of): Pancyentie Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed CAD that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): MeIabolie Physician/Medical If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, i 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be Other: 4 Nursing Home 5 M Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Man er of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 V Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 50 290 Shel MD

ARW

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

Dhi Rey

31. Date filed (Month, Day, Year)

SEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- 4

2008

110)

32. Registrants Signature

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Christa	nh	Mondruff	
CHIISTO	prier	Woodruff	

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	1- For State Registrar	Certif	ficate of Deat	h	R	eg. No.	00 0020
Physician/ Medical Examine	1. Decedent's Name (First, Middle,L	ast) Paul Woodruff				Day Year er 14, 2008	3. Time of Death 0111 hrs
	4a. Facility Name (if not institution, s Anne Arundel Medical C		4b. City, 1 Anna	own, or Location o		4c. County of D	del
Funeral Director	219 76 1517	Sex 7. Age (In yrs. last 49	birthday) If Und Month			12, 1959	Birthplace (State or breign Country) Washingtor
Aaryland Laa once. ector		Arundel 10c. City, To	own or Location	Annapo			10d. Inside City Limits  1 Yes 2 X No
with the Maryland ns 23a or 28a-f sho be notified at once.		ree Drive	10f. Zip	21 <b>40</b> 9		10g. Citizen of What 0	Country?
er death , or iter r must		12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2XX No seed If Yes 2 (1) Yes 2 (2) Yes 1 (2) Yes 2 (2) Yes 1 (2)	If Yes, speci		gin? ( Specify Yes or N , Puerto Rican, etc.)	14. Race - A White, et	merican Indian, Black, tc. White
5-0036 ed within 72 hours after bygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify Elementary/Secondary (0-12)	/ only highest grade completed)  College (1-4 or 5+)	6a. Decedent's Usual during most of wo Lak			16b. Kind of Busine	ess/Industry
				Jo	's Name (First, Middle, oan Clark		
AD 2 sho 27 is mati	Joan Woodruff,	mother	896 Chest	nut Tree	nber or Rural Route Nu Drive An	napolis, M	MD 21409
Baltimore, N permit. Pages I and Department of Healt Important: If item injury or other trau	20a. Method of Disposition  1 Burial 2 XX Cremation  4 Donation 5 Other Spec	Removal from State Ball	ince of Disposition (National International Creations of Creating	ematory	9/16/2008		re, Maryland
	21. Signature of Furreral Service Li	Relle	147 Dul	Address of Facilities  Ce of Glo	ucester St	Annapo	neral Home lis, MD 21401
Physician /Medical .xaminer	failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death. Do each line. Propoxphene a. hypertensive a Due to (or as a consequence of):	& Carisor	ródol in otic car	toxicatión diovascula	complica r disease	tingBetween Onset and Death
ted nisit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b.  Due to (or as a consequence of):  C.  Due to (or as a consequence of):					
760, ficate be executed sphysician and the burial - transit	events resulting in death) Last	d.  AMENDED 223a, 27, 2	8a-f, perN	1E, G884	10/10/08 T	'T	
ox 68 eath certil	■ IF FEMALE: ■ 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna 1 Live birth 4 Pregnant at time of deat	ncy 2 Fetal death	3 Ectop		23d. Date of de Month	livery Day Year
cords, P.O. B law requires that the d has been signed by the 2 should be detached	3	ns contributing to death but not res	ulting in the underlyin	g cause given in P		es 2 No 3	te to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the star death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact buffication: To Re Commission by Defitication: To Re Commission by Defitication.					per	opsy price formed? dea	re autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital Rec ysician: The I his certificate I director, page		Hospital: 1 Inpatient 2 ✓ E		26.Place of Death			
f Viv	1 V Yes 2 No		R/Outpatient 3 28b. Time of Injury	28c. Injury at Wor	Nursing Home 5 28d. Describ	Residence 6	Other:
Sion of Attending Ph ar death. ector: After t by the funeral	1 Natural 5 Pendir	(Month, Day, Year)	• •	1 Yes 2		, ,	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Contification:	2 Accident Investi 3 Suicide 6 X Could 4 Homicide	28e. Place of Injury - At hom	ne, farm, street, factor it a single	y, office building, e	etc. 28f. Location or Town Annapo	(Street and Number State) 896 Ch lis, MD	or Rural Route Number, City estnut Tree Dr
To the Hospital within 24 hours. To the Funeral completely filled		sician: To the best of my knowledge iner:On the basis of examination and	e, death occurred at th d/or investigation, in m	e time, date and p ly opinion, death o	lace, and due to the ca ccurred at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)
To with To com	29b. Signature and title of certifier	and manner stated.		O.C.M.E.			(Month, Day, Year)
	30. Name and address of person water Tasha Greenberg MD.	ho completed cause of death (Item 2 Assistant Medical Examir	ner 111 Penn	Street, Baltim	ore, MD 21201		
Stat Registra		2008 32. Figistrar's Signature	4 Soule	,			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** September 4 2008 James Floyd Woodland 11:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 26110 Loveville Road St. Mary's Mechanicsville If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1X M 2□ F 9, 68 1940 Maryland April **Director** 218-38-7776 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. on: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, The Medical Exeminar man be notified at my or other traumatic event, The Medical Exeminar man be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show adical Exeminer must be notified at 1 ☐ Yes 2 No Maryland St. Mary's Mechanicsville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 United States 26110 Loveville Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Howard Woodland Henreitta Veronica Thomas ဥ 19a. Informant's Name/Relationship (Type. Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Importent: If item 27 any Injury or other tr once. Mildred Veronica Stevenson 2213 Rand Place N.E. Washington D.C. 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 9/5/2008 Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Chronic Obsto **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 5 Other (specify) certificate has been signed by the rector, page 2 should be detached ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an autopsy performe funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation iours after death.

nerei Director: Af 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours a To the Funerei D 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0027189 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2417 Solomons Island Zoad. Huntietonn , 31. Date filed (Month, Day, Year) State 2008 SEP 0 Registrar 8

		1	For State of Maryland / Dep State Ce Registrar Ce	ertificate of Death		3. No. 2008 30209					
	hysicia	ın	1. Decedent's Name (First, Middle, Last)  Mary Emma Walls		2. Date of Death Month Septembe	Day Pear 3. Time of Death 5:15 p M					
-	/Medic xamin	_	4a. Facility Name (If not institution, give street and number)  14711 MT Calvert Rd.	4b. City, Town, or Location of Death	h	4c. County of Death Prince George's					
	neral ector		5. Social Security Number 220-40-6276   1   M 2   F   95   Yrs.	Upper Marlboro  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month Day	9. Birthplace (State or Foreign Country) 6,1912 Maryland					
Maryland	ied at		Usual Residence of Decedent  10a. State  Maryland  Prince George's  Brandyw			10d. Inside City Limits 1 □ Yes 2 No					
with the	a or 28a 1 be noti	۵	10e. Street and Number 15090 BR Walls Place	10f. Zip Code <b>20613</b>	10	g. Citizen of What Country?					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ral", or Items 2.	by Fu	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever In U.S.  Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give  Ye ar or Dates:	Was Decedent of Hispanic Origin? (S IfYes, specify Cuban, Mexican, Puerl 1 □ Yes X□ No Specify:		14. Race - American Indian, Black, White, etc.  Specify: White					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene.	than "natu Nedical	Completed	(Specify only highest grade completed)   (Giv	edent's Usual Occupation e kind of work done during most of wol DO NOT use retired) LS <b>T</b>	rking	6b. Kind of Business/Industry  (alls Florist					
land 2 Id be filed lental Hygi	ked other Ic event, I	To Be Co	17. Father's Name (First, Middle, Last)  James Richard Smith	18. Mother's Nar	me (First, Middle, Ma						
Mary nd 2 shou alth and M	27 Is mar r traumat		19a. Informant's Name/Relationship (Type. Print)  Doug Walls/Son  19b. Mai 15095	ling Address (Street and Number or Ri BR Walls Place,	ural Route Number, Brandywin	City or Town, State, Zip Code) e, MD 20613					
Imore, Pages 1 a	ant: If item ury or othe	Ì	4 Donation 5 Other (Specify)	Memorial Gardens	2008	Oc. Location - City or Town, State  Waldorf, MD					
Balt permit. Departr	any Inju					chols F.H., P.A., lotte Hall, MD 20622					
	ician dical niner		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	NoTIC CAUSION	ASCULA	Oncet and Death					
68760, tificate be executed	j pnysician and s the burial-transit	Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.									
Box (eath certi	for use a	Physician/Mec		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year					
rds, P.			Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown						
	s certificate has bed irector, page 2 sho	Completed by			24a. Was an autopsy performed?  1 \[ \text{Yes} \] 24b. Were autopsy findings available prior to completion of cause of death?} \]  1 \[ \text{Yes} \] 2 \[ \text{No} \]  1 \[ \text{Yes} \] 2 \[ \text{No} \]						
Vit /sicia	s certi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ EB/Outpati		ath <i>(Check only one</i> Home 5□ Besider	nce 6 Other (Specify) Living					
ם ק ק	Affer this funeral dir	Lü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 28b. Time Injury	of   28c. Injury at /	28d. Describe how	v injury occurred					
VISI r Atten ter deat	rector: by the	Certification: To	1 ☑ Actident   5 ☐ Pending   (Montin, Day, Year)   Injury   2 ☐ Accident   investigation   3 ☐ Suicide   6 ☐ Could not be   determined   28e. Place of Injury - At home, farm, s   building, etc. (Specify)	M 1 □Yes 2 ☑No	28f. Location (Str City or Town,	eet and Number or Rural Route Number, State)					
To the Hospital o	e runera	Medical C	29a. Certifler  (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.								
To th	compo		29b. Signature and title of certifier  Physician  Physician  Physician	29c. License number 29d. Date signed (Month, Day, Young) SEPT 8th.							
Y	4		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Suresh Verghese, 11701 Livingsto	,	Fort Has	hington MD					
	Stat	te	31. Date filed (Month, Day, Year)  32. Degistrar's Signature	Late	, LUIL WAS	mington, no					



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 🖓 🛭 🕄 Certificate of Death 2. Date of Death 3. Time of Death Day Year 0122 September 6, 2008

**Physician** Examiner **Funeral** Director 27 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Madical Examiner must be notified at 2 should be I tem 27 permit. Pages 1
Department of H
Important: If Ite
any Injury or ot

> Physician /Medical Examiner

ed by the ettending physicien and detached for use as the burial-transit : After this certifice e funeral director.

Box 68760

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Division of Vital Records,

or Attending after death. within 24 hours a

To the Funerel i

completely filled + IVA

1 - State Registrar 1. Decedent's Name (First, Middle, Last) William Ernest Weaver /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Havre de Grace Harford Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 21, 1919 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Maryland Months Days Hours 1**X** M 2 □ F 89 Yrs. 214-14-5242 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Directo Perryville Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34 Patterson Avenue 21903 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Specify: If Yes, Give Year or Dates: 1944-46 White è 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Perryville Supply Elementary/Secondary (0-12) College (1-4or 5+) Perryville, Maryland Twelve Years Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Johnson William W. Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael C. Weaver (son) P.O. Box 299, Perryville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09/10/08 Perryville, Maryland St. Mark's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signable of Funeral Service Licens 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine umonu that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Day Month Year 4□Pregnant at time of death 5 Other (specify) Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed2 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? death? 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARPORD MEMORIAL HERITAL, SO ( SONTH UNION AVENUE, HAVRE DE GRACE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

SEP 0 8 2008

			For State Registrar		State	ot Maryla	•	artment of F rtificate of I		Mental Hy	giene Reg. No.	2008	3	3021
	Dharisi		1. Decedent's Name	e (First, Midd	lle, Last)					2. Date of De				ime of Death
	Physici /Medic		Helen	Ann Y	lates					Septem	ber 1	, 2008	2:	10 P <sup>M</sup>
	Examir				on, give street and no	ımber)		4b. City, Town, or Location of Death 4c. County of Death					th	
			4748 B F					Harwoo				nne Ar		
	Funeral Director		5. Social Security N 219-72-50	98	6. Sex 1 □ M 2 💢 F	7. Age (In yi	rs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	). (Month, D	rth ay, Yea <i>r)</i> y 17,	9. Bir 1959 Dis	thplace (sountry) tric (	of Columbi
	and		Usual Residence of 10a. State	10b. County	у	10c.	City, Town or Lo	cation					10d. Ins	side City Limits
	Mary f sho	호	Maryland	Anne A	rundel	Har	rwood						1 [	⊒Yes 2∭ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Maryland Hygiene and Hygiene. The Maryland Hygiene and Indian Hygiene.  Department of Hygiene And Hygiene.  Department of Hygiene And Hygiene.  Department of Hygiene Hygiene.  Department of Hygiene.	irec	10e. Street and Nur	nber				10f. Zip Code			10g. Citiz	zen of What C	iountry?	
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	death	ner	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin?	(Specify Yes or N	0- 1	14. Race - Am		ian,
Maryland 21215-0036	ours after ral", or ite	by Fu	1 ☐ Never Marri 3 ☐ Widowed	ed 2∏ Mar 4□Divorced	Armed Frried 1 □Yes If Yes, G Year or [	2 X No ive		il Yes, spedily Cuba 1 □Yes 2 X No	Specify:	erto Rican, etc.)		Black, White Specify: W		
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ary	shoul nd M mar mar	-	19a. Informant's Na			DI.	19b. Mailir	ng Address (Street				Town, State.	Zip Code	)
	nd 2 alth a 27 is		Theodore	B. Yat	ces,Jr. /	Spouse		B Flander			-			
Je,	of Hermitem		20a. Method of Disp	osition		20b	. Place of Dispo	sition (Name of natory or other place	-	Date	·	cation - City or	Town, St	ate
Ē	Page nent d ant: If		1 X Burial 2 L 4 ☐ Donation	☐Cremation 5 ☐Other (8	3 ☐ Removal from Specify)			porial Garde		05/2008	Dunka	irk, Mar	vland	
Baltimore,	permit. Departr Importa any Inju		21. Signature of Eu	neral Service	Licensee		22	2. Name and Addre	ss of Facility Ra	ausch Fune	ral Ho	me, P.A.		736
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Ł	Physician	8	Immediate Cause (	Final	t only one cause on	1 00	MX (	uncer	_				Onse	t and Death
	/Medical		resulting in death)		Due to	(or as a cons		OV I CON					191	months
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	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death) L	injury ast	C	(or as a cons								
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P.O. Box (	The law requires that the death certi ate has been signed by the attending agge 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent in the past 19 1 □ Yes 2 9 □ Unknown		1 ☐ Live	itcome of preg birth 2□Fe gnant at time o nown	etal death 3	☐Ectopic pregnanc ☐Other <i>(specify)</i> _	у		2	23d. Date of de Month	elivery Day	Year
	that the ped by detact		Part II. Other signif	icant conditi	ions contributing to c	leath but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute t	o the cau	se of death?
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0	g Physer this	n:To	27. Manner of Death		28a. Date	of Injury	28b. Time o	28c. Injur	y at	Home 5 Res			ecity)	
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	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	1 Certifyi 2 Medical	ing Physician: To th I Examîner: On the and mar	e best of my k basis of exami nner stated.	nowledge, deat ination and/or in	h occurred at the ti vestigation, in my o	me, date and pla opinion, death oc	ice, and due to the curred at the time	e cause(s) , date and	and manner a place, and du	as stated. e to the c	ause(s)
	To the within To the Complex c	Ž	29b. Signature and	title of certifie	er		210	29c. Licens	e number		29d. Date	e signed (Mon	th, Day, Y	'ear)
			fle	ine	ne wer	my 1		DS	105		501	ptens	113	,2008
da	w 3		30. Name and address	ess of person	who completed cau	se of death (It	tem 23a) (Type,	Print) Gak Lo	ad EZ:	xo Ann	opoli	IS MO	02	1401
	Sta Registr		31. Date filed (Mont	th, Day, Year, SE	P - 4 2008	Registrate Sig	nature &	29c. Licens DS Print) Gak Lo	)	, ,		··· f		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 9-16-2008 Zimmerman 3:47 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Kline Hospice House Frederick Mt. Airy 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, Hours Days Months 216-30-3571 74 7-9-1934 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2 No Frederick MD Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6398 Overbrook Circle 21702 USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2K No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Inspector Airpax 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Elizabeth Iones Monroe Zimmerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sister Faye Mckay 6739 F Clifton Road Frederick, Md 21703 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 9-17-2008 Smithsburg, MD Smithsburg Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Fungral Service M01176 106 East Church Street Frederick, MD 21701 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final discrete or condition resulting in death) metastatic 6months Due to (or as a consequence of): obacco we Sequentially list conditions, Due to lor as a consequence of If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IE EEMALE utcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav gnant at time of death 5 ☐ Other (specify) เทกเพท Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evander must be nothing at

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Pages 1 and 2 of Health a item 27 is Funeral Director

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requires that the death certificate be executed the burial-tra physician use as for detached p signed t 2 should certificate has page To the Hospital or Attending Physician: funeral director. this After 1 within 24 hours after death. To the Funeral Director: A

Division of Vital Records, P.O. Box 68766%

23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ♠ No 9 ☐ Unknown	23c. If yes, or 1 ☐ Live 4 ☐ Pre 9 ☐ Unk

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

2 No 1 ☐Yes 2 MNo 1 Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 28d. Describe how injury occurred

9-16-2008

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of control 29c. License numbe D 43389

2 ER/Outpatient 3 DOA

30. Name and address of cers with your lived cause of death (Item 23a) (Type, Print)

Dr. Susan Brinkley M.D. 198 TJ Drive Frederick, MD 21702 31. Date filed (Month, I

1 Inpatient

Registrar

1 9 2008



Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:24 PM 09 19 2008 John William Anderson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Good Samaritan Hospital 8. Date of Birth (Month, Day, Year) 3-13-1947 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Months Hours 1 M 2□ F MD 61 Director 216-48-3314 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exacting contact to conflict an once. 10a. State 1 Yes 2 □ No Directo MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA 21218 Funeral 3822 Ednor Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of MD College (1-4or 5+) Elementary/Secondary (0-12) Security 12th grade 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Catherine Jenkins ဥ Carroll Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanette V. Anderson-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 19-25-2008 Owings Mills, MD Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H MD 21202 wa 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFRACTION /Medical Due to (or as a consequence of): Examiner MULTIPLE ORGAN FAILURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed HYPOXIC- ISCHEMIC ENCEPHALOPATHY Due to (or as a consequence of): physician sthe burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by sign be 1 √Yes 2 No 3 Probably 4 Unknown HYPERTENSLON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2010 certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#24aperPHYS G883 P6/24/08 Wental Hygiene

State Registrar

X

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Satishkabra MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATISH KABRA, GOOD SAMARITAN HOSPITAL, 5601, LOCH RAVEN BIVD, BALTEMORE, MD-21239 32. Registrar's Signature

MHOL

NDERSON

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

09/19/2008

08-07087 Kavitha Anandan Replacement
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

avitha Ananda		1- For State Registrar	Sta	ate of Marylar			of Health a of Death	na ivien	tai Hygiene	Reg. No	2008	30214
Physici Medical Exam		1. Decedent's Name		,					2. Date of Month			3. Time of Death 0903 hrs
		Kavitha 4a. Facility Name (in	Anand Anand Inot institution	lan n, give street and numl	ber)		4b. City, Town,	or Location			, 2008 c. County of Deat	
$\langle \rangle$		Harbor Hos					Baltimore					
Funeral Director		5. Social Security N			. Age (In yrs. 31	last birthday)		ear If Unde ays Hours	Min.	of Birth(MN . 16,	1977 9. Bi	rthplace (State or gn Duntry) India
any		Usual Residence of 10a. State	Decedent 10b. County		Inc. City	. Town or Lo	cation					10d. Inside City Limits
<b>*</b>		MD	Howard	4	1	umbia	Callon					1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Nur		4	1 001	diibia	10f. Zip Code	)		10g. Ci	tizen of What Cou	intry?
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Anandan				10h Mai	ling Address (Ct		a Nair	to Month of	O:t T Ot1	7: 0-4-)
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re, re I and FHealt Fitem er trau		20a. Method of Disp	osition	3 Removal from		Place of Disp	position (Name of other place)		Date		. Location - City o	
Baltimore, permit. Pages I ar Department of Hes Important: If itel		4 Donation 5	Other Sp	ecify:		.11top	Service	Corp.	9/19/08	Tov	vson, MD	
Balt permit. Departi Importi injury		21. Signature of Fur				22	2. Name and Address 2050 York	ess of Facilit	y Ruck To	wson l	uneral I	lome
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Divis pital or At ours after d eral Direct filled in by	Certification:	3 Suicide 4 Homicide		not be   28e. Place of mined (Specify)	ot Injury - At r	nome, tarm, s	treet, factory, offic	e building, e		ation (Street own, State)	and Number of R	ural Route Number, City
Hornical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and up to the cause(s) and manner stated.												
29b. Signature and title of certifier  29c. License number  O.C.M.E.										Date signed (Mo		
	-	30. Name and addre	ss of persolu	who completed cause	of death (Iter	n 23a)					,	
		Russell Alex		Assistant Me	dical Exar	niner 1	11 Penn Stree	et, Baltimo	ore, MD 2120	1		
St Regist		31. Date filed (Mont)	, Day, Year) V 1 7 7	32. Regi	strar's Signat	ure do	de			1582886		
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amend #State of Maryland Begaring to the alth and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 9-18-2008 **Physician** Edward W. Bartch /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5060 Wright Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 🖾 M 2 🗆 F 8. Date of Birth (Month, Day, 4–4–1929 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 79 **Director** 171-20-8673 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner man to nuffiled at Director Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 21205 USA 5060 Wright Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No ۵ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Steel Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward S. Bartch Levon E. Sampson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores McKenzie 7906 Roseland Avenue Rosedale, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/20/2008 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Bayview Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SchimunekFuneral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OF LARYNX **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 8BEST0515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans Due to (or as a consequence of) physician at the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 20€ No Certification: To

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p

27. Manper of Death  1 ☑ Natural  2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier    Check only one)   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and t	itle of certifie		- 2	So, License number	29d. Pate signed (Month/Day, Year)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death 10:05PM<sub>M</sub>

9. Birthplace (State or Foreign Country)
Pa.

White

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

Year

Day

State Registrar

Medical

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Z U U 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year SEPTEMBER 16, 2008 **Physician BARBATO** 8:46 P M LILLIAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD FOREST HILL FOREST HILL HEALTH & REHAB CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10-14-1925 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X I 82 219-18-5122 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 6820 Kelso Dr 21221 Items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examine one. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Elmer Lightner Nellie Furbush 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 Ruger Dr Bel Air, MD 21015 Richard Barbato (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery | 09-20-2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cissase or n july that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director. After this certificate has been signed by the attending physician and stely filled "by the funeral director, page 2 should be detached for use as the burial-transit stely filled." by the funeral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy perform  $C \checkmark$ A 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 032277 17,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 WEST MACPHAIL ROAD BEL AIR, MD. 21014 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

		_ For	Please	Type or Pri State of M		d / Depa	artment of I	Health and I				30217
		State Registrar				Ce	rtificate of	Death		Reg. No.		
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Examin		4a. Facility Name (If I						or Location of Death	1		unty of Death	
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			Usual Residence of Decedent							pray 20	,		
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantmer must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evaluation Armed Forces? 1 ☐ Yes 2 ☑ Note 1 Yes, Give Year or Dates:			Was Decedent of fYes, specify C 1√2 Yes 2 □ N			Specify Yes or I rto Rican, etc.)  Cuban	No-	14. Race - Am Black, Whi	ite, etc.
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Σ	and 2 saith a 27 is		Susan Bobes Wi	fe		P.O.	Box 591	Re	ister	stown,	MD 2	21136	
Baltimore, Maryland 21215-0036	of He		20a. Method of Disposition	7.5	20b. PI	lace of Dispo	sition (Name of natory or other p	olace)		Date	20c. Lo	ocation - City o	r Town, State
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	/Medical		resulting in death)	Due to (or as a									AND THE PERSON NAMED IN
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	pa ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a <b>End Sta</b>	consequ	ence of):	)isease						Month
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C			, I beabe						
50,	be ex cian a		resulting in death) Last	Due to (or as a	consequ	ience or):							
8760	cate I	dical		<b>d</b>									-
9 ×	ding se as	Me	IF FEMALE:	23c. If yes, outcome of	of nregna	ncv						004 D-1 - / -	
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 4 Pregnant at 9 Unknown	2 🔲 Fetal	death 3	Ectopic pregna Other (specify				- 1	23d. Date of d Month	Day Year
	s that med b		Part II. Other significant conditions	contributing to death but	t not resu	ilting in the u	nderlying cause	given in P	art I.	23e. Di	d tobacco	use contribute	to the cause of death?
δĒ	quire en sig uld b	pe pe								_ 1[	]Yes 2	No 3□	Probably 4 Duknown
$\mathcal{A} \mathcal{L}$ Records,	aw re	Completed by								24a. W		24b. Were	autopsy findings available o completion of cause of
100 m	The Ist te ha	E								- au	topsy rformed? 2 <b>X</b> No	prior to death' 1 □ Ye	?
<b>√</b> 2€	an: rtifica tor, p	Be C	25. Was case referred to medical	1				26. F	Place of De	1 ☐ Ye: eath (Check onl		, , , , ,	
>	lysicalis ce	.0	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗆	ER/Outpaties	nt 3 DOA	Other: 4	Nursing	Home 5 ☐ Re	esidence	6 □Other (S <sub>I</sub>	pecify)
0	ig Ph ter th neral	Ë	27. Manner of Death	28a. Date of Injury (Month, Day)	y Year)	28b. Time o Injury		njury at Vork?	-	28d. Describ	e how inju	ry occurred	
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Division of	r Atter de irecto	Certification: To	3 ☐ Suicide 6 ☐ Could not ! 4 ☐ Homicide determined	d 28e. Place of Injui building, etc.	ry - At ho (Specify	me, farm, str	eet, factory, offic	ce		28f. Location City or	(Street ar Town, State	nd Number or e)	Rural Route Number,
٥	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, sompletely filled in by the funeral director.			Physician: To the best o									
	he Ho in 24 I he Fu	Medical	(Check only one) 2 Medical Exa	amlner: On the basis of and manner stat		tion and/or ir	vestigation, in n	ny opinion	, death oc	curred at the tin	,		
	Vorth Con	Σ	29b. Signature and title of pertifier		7			ense num			29d. Da	atersigned (Mo	nth, Day, Year)
	(9)		30. Name and address of person who	completed cause of de	ah (Item	23a) (Type,					- (	1	
	$\mathcal{O}$		DAVID A. UTZE	SCHNEIDER.	M.	D	7601 09	SLER	DRI	VE TO	иогы	I, MARY	LAND 21204
		ate	31. Date filed (Month, Day, Year)	2. Registra	r's Signat	ture	is a						
	Regist	rar	SEP 2 2 201	UO JOHN	FS	- Allen							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan	•	artment rtificate			and M	ental Hy	giene Rag. No.	2008	30221
	Physici	an	Decedent's Name (First, Middle)	·							2. Date of Dea Month	ath Day	Year	3. Time of Death
1	/Medic	cal	Rita Joan Bono  4a. Facility Name (If not institution,		harl		4h Cin. I	Four or	Location of		Septemb		2008 ounty of Death	1:31 PM
1	Examir	ier	800 Ramshead (		Del)				svill				altimor	
	Funeral			6. Sex 7	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	th Voorb	9. Birth	place (State or Foreign
	Director		273-46-0442	1□M 2∏F	60	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da Aug 8,	1948	Miss	intry) Souri
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation				-			10d. Inside City Limits
	Maryl	ŗo	MD Balti	more		Cockey	79 <b>Vi</b> 11	P						1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	more		oberes	10f. Zip					10g. Citize	on of What Cou	intry?
	d within 72 hours after death with the Maryland liene. I then "neturel", or Iteme 23a or 28a-f ehow I'n Medical Examinar must be notified at	alD	800 Ramshead	Circle					210	30			USA	
	r dea	Funeral	11. Marital Status	12. Was Deced	dent Ever in U. ce <u>s</u> ?	.S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	- 14	Race - Ameri Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🖫 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 If Yes, Give Year or Da	•		1 ☐ Yes 2	No 🛣	Specify:			s	pecify: W	hite
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215	E = 5	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	4or 5+)	(Give	kind of worl DO NOT use	k done d e retired,	uring mos	t of workii	ng			
2	illed with Hygiene. other the	Completed	12	4	,									
and	o a a	Be	17. Father's Name (First, Middle, L James Michael		n						(First, Middle, Gauvir		umame)	
Maryland	d 2 should th and Men 7 is marke traumatic	ဥ	19a. Informant's Name/Relationsh			19h Mailir	ng Address	(Street a					Town, State, Zi	in Code)
	12 d 1 d 1 d 1 d 1 d 1 d 1 d 1 d 1 d 1 d		Maureen McLaugh		r						ckeysvi			030
je,	E E E		20a. Method of Disposition		20b. P	Place of Dispo	sition (Nam	e of	1		ate		ation - City or T	
Ē			1 ☐ Burial 2 ☐ Cremation 4 ※ Donation 5 ☐ Other (\$)		state	o	ratory or ou		1					
Baltimore,	permit. Pag Depertment Important: eny injury c once.		21. Signatu e d Fur H Sand L Ronald S	icensee Wade	rector		Name and ate A					Balt	imore S	Street
			23a. Part1. Buter the disease, or o shock, or heart failure. List of	complications that ca	used the death							rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_ a.	Nov	nauy	ai	Ne.	W.	dis	cas	l		Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a consequ	uence of):			X			-		
		er	Sequentially list concilions if any, leading to immediate	b. Due to (c	or as a consequ	uence o			A				-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
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9	eath certifice attending ph for use es t	Physician/Med	IF FEMALE:	23c. If yes, outc	omo of progra									
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live bir	th 2 ☐ Fetal int at time of de	Ideath 3	Ectopic pre					23	d. Date of delive Month	Day Year
P.O.	thet the de led by the a detached t	hysi	1 ∐ Yes 2 ∐ No 9 ∐ Unknown	9□ Unknov										
Records, P	8 50	by	Part II. Other significant condition	ns contributing to dea	ath but not resu	ulting in the u	nderlying ca	iuse give	n in Part I.			obacco use Yes 2□		the cause of death?
000	aw requir s been si 2 should l	Completed									24a. Was		24b. Were aut	opsy findings available
Ä	The lav	mo										osy rmed2 2 No	prior to α death? 1 ☐ Yes	ompletion of cause of 2□ No
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of \	iding Physician: th. After this certifice funeral director;	ို	1 ☐ Yes 2 ☑ No			ER/Outpatier			4 🗆 Nu	rsing Hor	~		Other (Spec	ify)
UC.	ding f	ion:	27. Manner of Death 1 Defaturat 5 ☐ Pending		Day Year)	28b. Time of Injury	M 28	Bc. Injury Work	at :? ∕es 2 🔲 I	i	28d. Describe I	how injury	occurred	
Division of	Attending r deeth.	fica	2 Accident investige 3 Suicide 6 Could n  4 Namerida	ot be 28e. Ptace of	of Injury - At ho	ome, farm, str					28f. Location (	Street and	Number or Rui	ral Route Number,
5	al or a after i Dire	Certification;	4 Homicide	buildin	g, etc. (Specil)	y)	,	,			City or Tox			
	To the Hospital or Attenc within 24 hours after deeth To the Funeral Director: completely filled in by the t	edical (	29a. Certifier 1 Cartifying (Check only one) 2 Madical E	Physician: To the lixaminer: On the bas	sis of examinat	wledge, death tion and/or in	n occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	nd manner as	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier		100000		29c.	License	number			29d. Date	signed (Month	, Day, Year)
C			> Small	UM)				DA	24	10		91	1510	5
(	(g)		30. Name and address of person v	no completed cause	of death (Item	7 23a) (Type,	Print)	_	1			10	1	<u> </u>
			12221	IULLA	mor	E 8	1)		Im	DU	uin	Mal	210	75
4.	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 2 2	2008	gistrar's Signa	Ans.	wer.							

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ,2008 September 19 Angela Bielatowicz Dolores /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Ctr. Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1□ M 2፟ F 219-28-1061 Maryland Oct30,1933 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. In the Marylan mut: If them 27 is marked other than "natural", or items 23a or 28a-f show unt: If them 27 is marked other than "natural", or items 73a or 28a-f show unty or other traumatic event, Its Maries Is as it is a feature of the statement of the Harford Bel Air 1 ☐ Yes 2X No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 U.S.A. 2403 Cool Spring Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary (Secondary (0-12) College (1-4or 5+) Hospital Operating Room Tech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Kowalewski Rose Yurek ပ 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2403 Cool Spring Road Bel Air, Md. 21015 Richard Bielatowicz 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. St. Stanislaus Cem 9-24-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facil Waczorowski Funeral Home, P.A. 1201 Dundalk Avenue Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6C1R6 MECLONICAL **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the burial-transi resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Tectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknew 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I s been signe should be d Completed by 1 Yes 2 No 3 Probably A Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 140 inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

of Vital To the Hospital or Attending Physician; Division death. filled in by the after death within 24 hours a completely

Medical Certification: To

4 Homicide 29a. Certifier

3 ☐ Suicide

29b. Signature and title of certifier

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DRING, SUITE 21/22B, BOLANS MODE 1014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -SIRITHAND, 260 & ANUGHA

31. Date filed (Month, Day, Year) SEP22

32. Registrar's Signature

ATTO AND

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ve ar **Physician** ANDRIW BISH 21:29 PM 09 16 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPIZING BAYVIEW BALTIMORE 8. Date of Birth May 12, 1910 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. 1 XM 2□ F Months Days Hours Maryland May 213-01-4356 98 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ages 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.

If if then 27 is marked other than "natural", or items 23a or 28a-f show or of other traumatic event, I as Wester Examiner must be notified at 1X Yes 2□No Director Baltimore City Md. 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 U.S.A. 6614 Hartwait Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify. Specify: ş 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Standard 6th Crater 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Szlachetka Bish George ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6524 Detroit Avenue Baltimore, Md. 21222 Eilene Miller (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ₩Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Sacred Heart of Jesus 9-22-2008 |Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FAILURE ZWEEKS RESPIRA TORY disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 2 WEEKS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 □ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES- 0 00 SEPTEMBER 16, 2009

DHMH 17 Bev 1/2001

State

Registrar

4940

EATERN WENUL, BALTIMORE, MD ZIZZY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

CHUNG,

A delication of

Registrar's Signature

CECILIA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9100 AM 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Peath 4a. Facility Name (If not institution, give street and number) **Examiner** m 0 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | Month, Day 9. Birthplace (State or Foreign 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 3 50-57 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, Ire Medical Examiner must be notified at anote. 1 Xes 2 No Director Himore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number HILTON Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) perator a 5th 18. Mether's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JR, Pages 1 and 2 S Ti 00 BerT 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Aurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 220 22. Name and Address of Facility 21. Signature Funeral Service 1229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 444 LUSIC /Medical Due to (or as a consequence of): 5000 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Ses 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X NO 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 | Yes 2 | ■ 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation To the Hospital or Attendin, within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 ☐ Medical Examiner: and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 55065 2008 who completed cause of death (Item 23a) (Type, Print) UNIVOF Maryland-GCC, 28 S. Becene St-NGEOG Balto MU 21201 Martin EdelMAN, MID Régistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 20

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 per doc g883 9-23-08 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:00 Day **Physician** Helen Joan Bart Ρ. 15, 200 Septembe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lorien Mays Chapel Rehab. Center Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 218-01-2237 1 □ M 2 □ F 87 Director 12/14/1920 Balt.,Maryland Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumalic event, it is Madical Experiment must be notified at once. Maryland Baltimore Towson 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21204 32 Dunvale Road Funeral America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2\ No Specify: þ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Hecht Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Michael Donnelly Sara Jane Byrne 2 19a. Informant's Name/Relationship (Type. Print)
Kathy S. Kreiner/ niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Meadow Creek Court Perry Hall, Maryland 21236 20b. Place of Disposition (Name of Carnetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 17, 2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chapel-Bel Air 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 40 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 5 ☐ Other (specify) signed by the a g | Unknown g Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autops 1 ☐ Yes : After this certification and after the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury a Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director: d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar 31. Date filed (Month, Day,

32 Registrar's Signature

and manner stated

death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

08-07038 Jerome Carter Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

lerome Carter		State of Maryland / Departmen - For State	t of Health and Mental Hygic of Death	ene 2008 3022
Physicia	ın/	Decedent's Name (First, Middle,Last)		ate of Death fonth Day Year eptember 14, 2008  3. Time of Death 1332 hrs
Medical Exami		Jerome Carter  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Southern Maryland Hospital	Baltimore	Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hrs. 8. Months Days Hours Min. 9	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 4-23-1949 Country) Washington DC
- Se	-	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or I	Location	10d. Inside City Limits
Maryland 28a-f show any d at once	_	MD P.G. Clinton		1 X Yes 2 No
1arylar 28a-f s	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
h the Ma 3a or 28	ä	11814 Mary Catherine Dr.	20735	U.S.A.
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? X  1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year	3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican  1 Yes 2 No specify:	
ours afi atural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	cedent's Usual Occupation (Give kind of working most of working life. DO NOT use retired)	done 16b. Kind of Business/Industry
21215-0036  uld be filed within 72 hours    Mental Hygiene marked other than "natur ic event, the Medical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Bus	Operator	Metro
21215-003 uld be filed withi Mental Hygiene, marked other ti		17. Father's Name (First, Middle, Last)  Lorenzo Carter	18. Mother's Name (Fin Audrey Ca	st, Middle, Maiden Surname)
212 uld be Menta mark c even	<b>m</b>			Route Number, City or Town, State, Zip Code)
MD d 2 sho lth and n 27 is		bridg bolles carter/wire		e Dr. Clinton,MD 20735
Baltimore, MD 212 permit. Pages I and 2 should be Department of Health and Menti- Important: If item 27 is mark injury or other traumatic even		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Conation 5 Other Specify:  20b. Place of Corematory Resurr	ate 20c. Location - City or Town, State -08 Clinton, MD	
Balt permit. Departi Import	1	transled Jack	108 W. North Ave.	ld Taylor II Funeral Mm BAltimore, MD 21201
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.		spiratory arrest, shock, or heart Approximate Interval Between Onset and Death
-xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Chronic alcoholis  Due to (or as a consequence of):	m	Death
,		Sequentially list conditions.		
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
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Records, P.O. Box 68760,  The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery  Month Day Year
Box e death c the atten ed for us	hysi	1 Yes 2 No 9 Unknown g Unknown		
, P.O. res that th signed by be detach	þ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1
Division of Vital Records, rate dear require and or Attending Physician: The law require and are death.  All Directors. After this certificate has been sided in by the funeral director, page 2 should be a been and or the funeral director.	Completed			24a. Was an autopsy performed?  1 ✓ Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical	26.Place of Death (Check only	
Vita hysicis this ce al direc	To Be	1 V res 2 No	patient 3 DOA Other Nursing H	
Division of Nipial or Attending Phyours after death.		(Month, Day, Year)	ne of Injury 28c. Injury at Work? 28	d. Describe how injury occurred
ivision  or Attend  after death.  Director: d in by the 1	Certification:	2 Accident Investigation		f. Location (Street and Number or Rural Route Number, City
Divi	ertifi	3 Suicide 6 Could not be determined (Specify)	i, street, leadery, ember banding, etc.	or Town, State)
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifit completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner: On the basis of examination and/or invited the control of the control of the basis of examination and or invited the control of the control	occurred at the time, date and place, and due estigation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
To To com	Med	and manner stated.  29b. Signiture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		( and of out	O.C.M.E.	September 15, 2008
7		30. Name and address of person who completed cause of death (Item 23a)		
0		4	Penn Street, Baltimore, MD 21201	
S Regis	tate trar	CED 9 9 /IIIIA LAGRAGARA ANT		

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		-	For State Registrar	State of Ma	ryland		artment tificate			and M		iene2	008	302	227
Phys	sicia	_	1. Decedent's Name (First, Middle, Last)	Bertha	Ma	e Day	, ; A				2. Date of Dea Month	Day	2008	3. Time of I	
	edic	600	4a. Facility Name (If not institution, give s		ria	е ра	4b. City, To	own, or L	ocation o	f Death			nty of Death	10.10	
LAG	2111111		6503 Park Heig	hts Ave	nue		Bal					N/	A		
Fune			5. Social Security Number 6. Sex			st birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	, Year)	9. Birthp		<sup>r</sup> Foreign
Direct	tor	-	216-30-8505 Usual Residence of Decedent		/5						4-4-	1933		S.C.	L
ryland how	E E	_	10a. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City	
ne Ma 8a-fs	Dalliled	Director	MD N/A		Balt	imor		D- d-				On Citinon	Albet Cour	1 TYes	
with the	De u		10e. Street and Number	- t 7			10f. Zip (				'	0g. Citizen o		itry ?	
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after or ite	la la la la la la la la la la la la la l		1 Never Married Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	0		1⊡ Yes 2√		Specify:	i, Pueito i	nican, etc.)	Spe	lack, White,	ec. Black	
d within 72 hours af giene.  Pr than "natural", or the Medical Exam.	II EXA	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			∠ dent's Usual		ion		- 1		Business/In		
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be filed ntal Hygi	event	Be	10th grade   17. Father's Name ( <i>First, Middle, Last</i> )				•		18. Mothe	r's Name	(First, Middle,				
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mit. Pages 1 are partment of Heal portant: If item	יף פי		1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			moria		K S	9-26	-2008	Randa	allst	own, l	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27.3 is marked other than "natural", or items 23a or 28a-f show any intury or other trainmatic event it he Madical Examiner must be notified at	any inju		21. Signature of Funeral Service License	wo		2	2. Name and			. 110	arch E Avenue		•	2120	)2
Physici /Medic			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each line.  CoLO Due to (or as a	CAN	cer	er the mode				r respiratory ar	rest,		Approximate Interval Bety Onset and D	ween
te be executed was a way sician and which transit		ical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a											
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I or Attending Physician: The law requires tarter death.  I prector; After this certificate has been signed in but the funeral director hand 2 should have	N	Completed									24a. Was a autop perfor 1∐ Yes		prior to co death?	opsy findings a ompletion of ca	
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Jing Phys Jing Phys After this	eral di	2	1 ☐ Yes 2 XNo 27. Manner of Death	1 ☐ Inpatie	y 2	28b. Time o	nt 3 DO/	Bc. Injury	at at		me 5 Resid 28d. Describe h			ty)	
Attending r death.	e run	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М	Work? 1 □ Y	? es 2 🔲	No					
or Atte	n by tr	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc	ry - At hom :. (Specify)	ne, farm, st	reet, factory,	office		1	28f. Location (S City or Tow	treet and Nu n, State)	mber or Rur	al Route Num	iber,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his commissive filled in by the funeral director name.	rely filled i	Medical Cer	29a. Certifier 1 Certifying Physical (Check only one)	ner: On the basis of	examination										3)
o the ithin 2 o the	ompie	Mec	29b. Signature and title of certifier	and manner sta	ieu.		29c.	License	number			29d. Date sig	ned (Month	, Day, Year)	
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1			30. Name and address of person who co	mpleted cause of de	eath (Item	23a) (Type,			11	-	) 0	AA	1	ber 22 tomd:	7100
U	Q		MARUN FELDMA	NMD	Medi	icall	molo	94-1	Her	nata	olgy at	Mercy	Dal	to/nd.	41202
Reg	Sta gistra	_	31. Date filed (Month, Day, Year) SFP 2 2 2008	32. Registra	a s Signati	10841	9				0 '	,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** A DUBLIN 4 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimor e Rosedale FRANKLIN Square Hospital Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 □ M 2 🕱 F 218-64-2704 JUNE 25,1954 Director 54 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2 □ No Director BALTIMORE TURNER STATION MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 653 S. AVONDALE ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 □Yes 2 No Specify ģ Specify. 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed withir Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) POSTAL WORKER US POSTAL SERVICE is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ERNEST DUBLIN ပ္ LAURA BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traugure. TRENIA DUBLIN/SISTER 4032 PAIGE VIEW ROAD RANDALLSTOWN, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Purial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILL MEM. GRDNS. 9-24-2008 | MIDDLE RIVER, MD 22. Name and Address of Facility 21. Fignature of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** en neels /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical the attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Ye ar Day 5 Other (specify) P.0. 1 □Yes 2 □No 9 Unknown ģ signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 s autopsy performed certificate 1 ☐ Yes 1 ☐ Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

eral Director: A
filled in by the fu 1 ☐ Yes 2 □ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

96 State Registrar

K Cod Burak 31. Date filed (Month, Day, Year) SEP 2 2 2008

29b. Signature and title of certifie

30. Name and address of person

9000 FRANKLIN 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D67855

Balto

Sauare

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

1- State Amend 16a, perFH G883 9/22/08 Entificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year 12300 M 18,2008 DAISY Dingle 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GNE mok If Under 1 Year 8. Date of Birth (Month, Day, Dec. 31 9. Birthplace (State or Foreign Country)
S.C. 5. Social Security Number 7. Age (In vrs. last birthday) Months Hours Days 1 ☐ M 2 ☐ F 217-22-6314 89 ,1918 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location BALTIMORE MD n/A 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 551 THORNFIELD 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: BLACK Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired)

Supervisor, Housekeeping 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9 TH College (1-4or 5+) HILTON HOTEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES DUKES DAISY FELDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, Md. DAISY NORRIS /daughter 551 Thornfield Rd 21229 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DABurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Sept.25,2008 Balto,Co.Md MEMORIAL PK. 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME maaine 1412 E. PRESTON ST. BALTO, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final 01 disease or condition resulting in death) my Due to (or as a consequence of): apach 0 Se\_uentiall\_list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Physician: The law requires that the death certificate be executed P.O. Box 68760, Records, Vita ot Division Hospital or Attending **Physician** 

/Medical

**Examiner** 

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is No Item Examiner must be notified at

Physician

/Medical

Examiner

burial-transit

the

certificate

director

filled in by the

altimore, Maryland 21215-0036

attending physician for use as the burial this after death Director: within 24 hours a To the Funeral C

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b Signature and title of certifier

2

29c. License number

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician SIMA DOBKINA SEPTEMBER 18 2008 6:24A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13 TIMBER WAY COURT BALTIMORE REISTERSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
UKRAINE 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 💢 F 89 215-45-4766 Director 09/01/1919 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventhan must be notified at 1 ☐ Yes 2 No Director BALTIMORE REISTERSTOWN MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 USA 13 TIMBER WAY COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE þ Specific 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) MEDICAL DOCTOR GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be **EVSEY** DOBKIN IDA DOBKINA ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trau DMITRIY ROSSIKHIN / GRANDSON 13 TIMBER WAY COURT, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/19/2008 REISTERSTOWN, MD BALTIMORE HEBREW 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final carcinoma 7 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off attending physician and for use as the burial-tran Due to (or as a consequence of) The law requires that the death certificate be ex Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 Yes 2 No signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 21 No Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 1 X Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending within 24 hours efter death.

To the Funeral Director A
completely filled in by the fu 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier September 18,2008 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) rd 31. Date filed (Month, Day, 32. Registrar's

Registrar

08-07016 James Dent

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 30231

		For State		Certifi	icate of	Death				F	Reg. No.			
Physician		egistrar . Decedent's Name (First, Middle,Lasi	:)							Date of De		Year	3	. Time of Death
edical Examine		James B. Dent	Jr.							Month Septemb				2103 hrs
	4	a. Facility Name (if not institution, give	e street and number)		41	. City, Tov		ation of D	Death .			. County of	Death	- 10
	ı.	Howard County General H	pspital			Columi	bia			4000		loward		
Funeral	5	. Social Security Number 6. Se	7. Age	(In yrs. last	birthday)	If Under		If Under 2		8. Date of E				place (State or
Director	b	15-56-9550	M 2 F	57	Yrs.	Months	Days	Hours	Min.	05-2	7-19	951	Coun	<sub>try</sub> Maryland
		Isual Residence of Decedent												
any	_	0a. State 10b. County		10c. City, To	wn or Location	on								Od. Inside City Limits
<b>≱</b> "		MD Charle	es .	Brya	n's R	a								1 <sup>X</sup> Yes 2 No
faryland 28a-f show	3/1	0e. Street and Number				10f. Zip C	ode					izen of Wh	at Counti	γ?
ihe Maryland a or 28a-f sh	1	108 Gentry Ct.				2061	16				U.S	. A .		
ith th		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	Decedent	of Hispar	nic Origin	? (Spec	cify Yes or I	No-			an Indian, Black,
ath w	niera	1 X Never Married 2 Married	Armed Forces?	X No		es, specify	_		uerto R	ican, etc.)		White	, etc.	
r or ", or	- 1	3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year	NO	1	Yes 2	No s	specify:				Specify:	Blac	ck
irs afi	<b>∂</b>	15. Decedent's Education (Specify of	or Dates:	npleted) 1	6a. Deceden	's Usual O	ccupation	(Give kir	nd of wo	rk done	16b.	Kind of Bu	siness/In	dustry
2 hou		Elementary/Secondary (0-12)	College (1-4 or	5+)		ost of worki		O NOT US	se reure	u)	Pr	ivat	е	
thin 7 than than edica	힐	12th			Maint	enan								
21215-0036 uld be filed within 72 how Mental Hygiene, marked other than "nat	Completed	17. Father's Name (First, Middle, Las	.)				18.	.Mother's	Name (	First, Middle	e, Maide	n Surname	)	
215 oe file ntal H ked o	e l	James B. Dent	Sr.		Chapter Hardware	-0	A.	lice	<del>)</del>	Pos	еу			
21215-0036 hould be filed within 77 and Mental Hygiens, is marked other than tite event, the Medical		19a. Informant's Name/Relationship (	Type, Print )		19b. Mailing									
iore, MD 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. : If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.		Alice R.Dent/Me	other		108	Gent	ry (	Ct.	Bry	an's	Rd.	MD :	2061	6 Fown, State
t e lea a	Γ	20a. Method of Disposition  1 X Burial 2 Cremation 3	Bomoval from St	cre	ematory or other	ner place)								
ages nt of nt: If				™ bM	Veter	ans (			09-	24-0	8   CI	Jetre	enna	m,MD
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is in injury or other trauman	1	4 Donation 5 Other Specification of Funeral Service Lice			22. N	lame and A	Address o	f Facility	Ron	ald '	ray1	or I	ΙF	uneral HM
Depri		An ald she	11-12			B W.								1201
Physician	7	23a. Part I. Enter the disease, or com	plications that caused	the death. [	Do not enter t	he mode of	f dying, su	uch as ca	rdiac or	respiratory	arrest, s	hock, or he	art	Approximate Interval Between Onset and
Medical	1	failure. List only one cause on e	each line. <sub>a.</sub> Large bowel ob	struction										Death
kaminer	-	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		:									11
	- 1	Sequentially list conditions,	Sigmoid colon	volvulus										
	į	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of):	:									
	Examiner	(Disease or injury that initiated	Due to (or as a cons	sequence of):										
ecuted and - transit	ا <u>ٽ</u>	events resulting in death) Last	_											
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760, frate be executed sphysician and the burial - transi	Medical	IF FEMALE:	23c. If yes, outco	ome of prean	ancv						7	23d. Date o	f delivery	,
876 ificat ig phr		23b. Was decedent pregnant in the	1 Live birth	omo er pregn	2 F	etal death	3	Ectopic	pregna	ncy	- 1	Month	[	Day Year
n of Vital Records, P.O. Box 687 diag Physician: The law requires that the death certifi. h. After this certificate has been signed by the attending inneral director, page 2 should be detached for use as	sician	past 12 months?		at time of dea	ith 5 0	ther (Spec	cify)				. 1			
BO death	Phys	1 Yes 2 No 9 Unknow	9 CHRIOWII							02a F	Vid toboo	no uno con	ribute to	the cause of death?
at the	E	Part II. Other significant condition	s contributing to dea	ath but not re	sulting in the	underlying	cause giv	ven in Pa	ηI.					pably 4 Unknown
signe be de	d by									1				utopsy findings available
rds requi	Completed									l a	Vas an iutopsy		prior to	completion of cause of
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ding Afr	on:	1 Natural 5 Pending	28a. Date of Ir (Month, Day	y,Year)		· · ·	1Y	es 2	No					
Sior Vittend death. sctor:	Certification:	2 Accident Investig		Injury - At ho	me farm str	eet, factory	, office bu	uilding, et	ic.	28f. Locat	ion (Stre	et and Num	ber or R	ural Route Number, City
lor dint	Ţ.	3 Suicide 6 Could r	lot be	injury raine	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		0.		or To	wn, State	:)		
spita hours		4 Homicide	sician: To the best of		an doath ann	urred at the	stime da	te and pla	ace, and	due to the	cause(s	) and mann	er as sta	ted.
Division  To the Hospital or Attenwithin 24 hours after dealth To the Funeral Director:	cal	(Check only one) 2 Medical Exami	ner:On the basis of e	my knowledg xamination at	nd/or investig	ation, in m	y opinion,	, death of	curred a	at the time,	date and	place, and	due to t	he cause(s)
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	2	250 Signature and title of certifier		1		-	O.C.1				9	Septemb	er 14,	2008
		Murch	M	1	-		3.0.1							
1		30. Name and address of person w				enn Stree	et Ralti	impre	MD 21	201				
V			ssistant Medical										-	
St	ate	31. Date filed (Month, Day Year)	2 2008 <sup>32. Re</sup>	trar's Signatu	JA. A	Joseph								

		1 - For State Registrar		ar y larra	•	rtment of F tificate of			Reg. No.	08	30232
		Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death
Physicia		Lois Frampton	Four	rnier				Month	ber 20	Year 2008	6:00 A M
/Medic		4a. Facility Name (If not institution, give str				4b. City. Town, o	r Location of Death		4c. County		0.00 /
Examin	er	Carroll Luth. Villa			o Ctr	•	stminster			Carro	11
Euroval		5. Social Security Number 6. Sex		je (In yrs. last		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthpi	ace (State or Foreign
Funeral Director		218-22-4591	M 221F	90	Yrs.	Months Days	Hours Min.	Oct. 2	<sup>th</sup> Year) 2, 1917	Mary	yland
		Usual Residence of Decedent						1			
ylan		10a. State 10b. County		10c. City, T	fown or Loc	cation				10	Od. Inside City Limits
Ma a-f-a	ğ	Maryland Carro	11			Westmin	ister				1 🛣 Yes 2 🗆 No
ours after death with the Marylan rail, or items 23s or 28s-f show	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
th wil		205 St. Mark Wa	y, Apt.	408		21	1158		U.:	S.A.	
dea	Funeral	11. Marital Status	2. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rad Bta	ce - Americ	
afte afte		1 Never Married 2 Married	1 ☐ Yes 2X			☐ Yes 2 No			Specif	iv-	
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it. Printmen		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		Dula	ney V	alley Me	m. 9/23/	/2008	Timoniu	ım, MU	)
permit. Page Depertment of Important: if any injury or once.		21. Signature of Full dial Service Cicensee	V6. 1	Pon	,		ss of Facility Hat				16
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			For State Registrar		State of Ma	ıryıanı		epartment c Certificate				Reg. No.	Z 11117	30233
				e (First, Middle, Las	st)		-				2. Date of De	eath Day	y Year	3. Time of Death
	Physicia /Medic		DONAL	D FREEMA	N FOXWORT	ΉV				C	Septemb		8.2008	1:10A M
	Examin				e street and number)			4b. City, Tow	n, or Loc	cation of Death	1		County of Dea	
3			Oak Crest	Care Cer	nter			Parkv	ille	1			Baltim	ore
Soct.	Funeral		5. Social Security N	lumber 6. S	ex 7. Age	(In yrs. I		(ay) If Under 1 Y	ear If	Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date March 5,	rth ay, Year)	9. Bir	thplace (State or Foreign
₹ I	Director		548 <b>-1</b> 8-66		X <sup>M 2□</sup> F 83	}	Yr	s.	,,		March 5,	1925	Ca.	lifornia
/~ -	pun \star		Usual Residence of	Decedent 10b. County		10c City	/ Town o	r Location						10d. Inside City Limits
37	sho	'n												1 □Yesvat□ No
#	he M	Director	Maryland 10e. Street and Nu		e	Ва	ltim	10f. Zip Co	40			10a Cit	izen of What Co	2111
FOX WORTHY	death with the Maryland ms 23a or 28a-f show				1			101. Zip Co	212	12		rog. Cit	USA	ountry:
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×.	item	5	11. Marital Status	ied XX Married	Armed Forces? XXYes 2 □ N			<ol> <li>Was Decedent If Yes, specify</li> </ol>	Cuban, N	Mexican, Puerto F	Rican, etc.)	_	Black, Whit	
压器	rs aff	by	3 ☐ Widowed		If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐	No S	pecify:			Specify:	White
3 FJ 5-003	2 hou	ted		15. Decedent's Ed	lucation		16a. D	ecedent's Usual O	ccupation	n		16b. K	ind of Business	/Industry
23	hin 7;	Completed	(Spec	only highest gra	de completed) College (1-4or 5	+)	(C	Give kind of work d fe. DO NOT use r	one durir etired)	ng most of workin	ng			
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₹ <u>ē</u>	uld b Ment arked	ပ္	William				Fox	worthy		Gertrude	e			Fallon
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	s 1 an of Heal item 2		20a. Method of Dis	position		20b. P	lace of D	isposition (Name o	of r place)	D	ate	20c. Lo	ocation - City or	Town, State
(% /	Page ment c ant: If ury or		1 ☐ Burial 2X	Micremation 3 ☐ 5 ☐ Other (Specifi	Removal from State			nt Cremator	У	Sept 1	,			Maryland
9/18/08 Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evancies must be recified at once.		27. Signature of Fo	uneral Bervice Licer	h Render	(in)		22. Name and A		<sup>f Faci</sup> litiche k Road Ba				
		_	23a. Part 1. Enter 1	he disease, or com	plications that caused one cause on each lin	the death	n. Do not						10120	Approximate Interval Between
	Physician		Immediate Cause		0			C	(45)					Onset and Death
	/Medical		resulting in death)		a. Due to (or as	consequ	_	Fariu						
	Examiner				En	l sto	CA	emphyse	ma					
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// <sub>20</sub>	tificate be executed ig physician and as the burial-transit		resulting in death)	Last	Due to (or as	a consequ	Jence of)	•						
09289	physi the l	edical		•	d									
	certifind rise as		IF FEMALE:	A	23c. If yes, outcome	of pregna	ncy						23d. Date of de	livery
Вох	The law requires that the death cert ate has been signed by the attendin bage 2 should be detached for use a	Physician/N	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal	death	3 ☐ Ectopic preg 5 ☐ Other (speci					Month	Day Year
0	w requires that the de been signed by the should be detached	ysi	1 ☐ Yes 2 l 9 ☐ Unknown		9 🗆 Unknown									
σ.	that ned b		Part II. Other signi	ficant conditions o	ontributing to death bu	ıt not resu	ulting in th	ne underlying caus	e given ir	n Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
Ę	quires an sig uld be	ed by	COPD,	interstit	ial lung di	seas	e 1	nyelody	s pla	isia	10	Yes 2	□ No 3□ P	robably 4 🗌 Unknown
္မ	s bee	Completed			7		/	0 /	'		24a. Was		24b. Were a	utopsy findings available
æ	The law te has age 2 s	mo										ormed?	death?	completion of cause of
<u>fa</u>	an: tiffica tor, p	BeC	25. Was case refer	red to medical					26	S. Place of Death	1 ☐ Yes		1 1 10 10:	s 2 No
<u> </u>	Physician: r this certificanal director, p	To B	examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outp	atient 3 DOA		4 Nursing Hor			6 ☐ Other (Spe	ecify)
<u> </u>	ding Physician: The In. After this certificate hater the director, page	T:U	27. Manner of Deal	th	28a. Date of Inju (Month, Day	ry (Year)	28b. Tin Inju	ne of 28c.	Injury at Work?		28d. Describe			
.0	ath. or: Af	atic	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	1	, , , , , ,	,.	М		2 □ No				
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inju- building, etc	ry - At ho . <i>(Specif</i> )	me, farm	, street, factory, of	fice	2	28f. Location City or To			ural Route Number,
_	Hospital 24 hours Funeral etely filled		29a. Certifier (Check only	1 CertifyIng Ph	nysician: To the best	of my kno	wledge, o	death occurred at	he time,	date and place,	and due to the	e cause(s	s) and manner a	as stated.
	To the Ho within 24 To the Fu completel	Medical	one)		niner: On the basis of and manner sta		uon and/				cu at trie time			
	5 vit	~	29b. Signature and	une of certifier				290. L	cense nu	70-		290. D8	ate signed (Mon	(II, Day, real)
			大人	aha D	you M	D			161	185		9	/18/0	75
	13		30. Name and add	ress of person who	completed cause of d	eath (Item		alther	Blu	d, Park	ville M	07	12.34	
	Stat Registra		31. Date filed (Mor	0000	32. Registra	ar's Signa	ture	de		)			,	
	3,000		GE	14 14 m	(E)		6							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Physician George Samuel Farmer III 5:40 PM SEPTEMBER 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CIVISTA MEDICAL CENTER A PLATA CHARLES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F Months infant Director 53 Sept 15, 2008 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Director MD Prince George's Brandywine 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 10505 Cedarville Road #416 20613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify þ Specify: biracial 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) injury or other traumatic event, the infant infant infant 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) George S. Farmer Jr ပ္ Angela Kramer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Civista Medical Center 5 Garrett Avenue LaPlata, MD 20646 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state Ronald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consenience of): Nonviable newborn /Medical **Examiner** Very low Due to (or a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1. Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

with the Maryland

"natural",

1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than

Hospital or Attending Physician: The law requires that the death certificate be execute

After

within 24 hours a

attending physician

Division or Vital Records, P.O. Box 68760,

SAMUEL

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RMER

Saltimore, Maryland 21215-0036

SEP 2 2 2008

Mo (Wiltrout)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Lisa M. Wiltrout 701 East Charles St. P.O. Box 1070 Laplata, MD

2. Registrar's Signature

29c. License number

D0057484

29d. Date signed (Month, Day, Year)

9/15/08

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) () Month Year **Physician** LE MING 18,2008 DOV GLAS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/ If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign (Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** -631 12 M 2 F Days **Director** Sou Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location ust be rightled at i Yes 2 □ No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. or other traumatic event, I'm Medical Examiner. orces? 2 ☐ No Armed Forces' 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Indust 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) naintenance 18. Mother's Name (First, Middle, Maiden Syrname) 17. Father's Name (Firşt, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory opother) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 75 ☐ Other (Specify) Funeral Service License 21. Signature 21229 23a. Patty. Enter the disease, or complications that caused the shock, of heart failure. List only one cause on each line. Immediate Gadse (Final disease or condition resulting in death) Approximate Interval Between Onset and Death sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burian Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed' this certificate 1 □ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation

**Hospital or Attending Physician**: The law requires that the death certificate be executed 24 hours after death. Box 68760, P.O. Division of Vital Records, To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

Medical Certification: To

1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day,

State Registrar PHYSI CIAN

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 TYes

2 🗌 No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST

BALTIMORE MD 21223

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1940 BALTIMORE SANDHU W. MD

6 ☐ Could not be

determined

egistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar GREEN!

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BACTIMORE

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32. Registrar's Signature

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<sup>Year)</sup> 2008

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31. Date filed (Month, Day, SEP 2 2

			For State Registrar	State of Ma	aryland /	-	rtment of H tificate of L			giene Reg. No.	2000	20237
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-34	Physicia /Medic		Ada Ruth Goodwi						Septemb		9, 2008	12:02P <sup>M</sup>
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7.	Funeral		5. Social Security Number		e (In yrs. last	birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da			lace (State or Foreign
	Director		193-24-7289	1□ M 2√2 F	76	Yrs.	World S Bays	Trodio IIIIII	2/8/19	32		ýlvania
	/land	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	cation				10	0d. Inside City Limits
	a-fsh	ctor	MD Carrol	1	West	minst	ter					1 □Yes 2 No
	/ifh th	Director	10e. Street and Number 903 Boxwood Roa	<b>-</b> f			10f. Zip Code <b>21157</b>		1	10g. Citiz	en of What Coun	try?
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Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Modical Experience rout Le natiles" at	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	No		Was Decedent of H fYes, specify Cuba I□Yes 2⊠No	n', Mexican, Puerto Specify:	Rican, etc.)		Black, White, e Specify: Whit	
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Ball	permit. Pages Department of Important: If is any injury or once.	e y	21. Signature of Funeral Service	)ay		Rt.	Name and Addres	<sup>ss of Facility</sup> To n Funeral	wson, M Home,	laryl Inc.	and 2120 1050 Yo	14 ork Road
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	To the within to the comp	M	29b. Signature and title of certifier	Linter	MD	)		5392	_	9	e signed (Month,	8
	107		30. Name and address of person v	ho completed cause of d	leath (Item 23	3a) (Type,	Print)	2 51 1	UESTH	ING	TER M	021157
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DHMH 17 Rev 1/2001

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н	Examin	er	4a. Facility Name (If not institution, give s  CAPROL HOS PICE	street and number)		1	, Town, or MINISTER	Location of	f Death		4c. 0	County of Death Ca	rroll
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Jan 7,	, <sub>Year)</sub> 1956	Col	place (State or Foreign intry) 1and
	and w		Usual Residence of Decedent  10a. State 10b. County		ty, Town or L	ocation							10d. Inside City Limits
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	or 28a	Jirec	10e. Street and Number				p Code			1	_	en of What Cou	untry?
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Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		treet, facto	ry, office		2	28f. Location (5 City or Tow		l Number or Ru	ral Route Number,
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	_		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type	, Print)					1/	5/00	
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DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 5:55 A. 9/17/2008 Mary S. Gross /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Nursing Home Timonium If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F 210-10-7862 91 Director 9/11/1917 Permsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

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Department of Health as
Important: If item 27 Is
any injury or other trau 15 Dulaney Hills Ct. Hunt Valley, Maryland 21030 Jacqueline Koper/ daughter 20b. Place of Disposition (Name of Penni Lift Colin Menorial Park September 20c. Location - City or Town, State 20a. Method of Disposition N. Huntingdon, Natural 2 ☐ Cremation 3 ☐ Removal from State 19, 2008 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvánia 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, in each line. Immediate Cause (Final **Physician** ementio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transi attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📉 No Month Year 5 ☐ Other (specify) the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? aw 24a. Was an certificate has autopsy performed The 2 No 1 □Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4- Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-™Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours after To the Funeral Dire Hospital 29a. Certifier 🗚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 200 Chaben ERNESTINE Who completed cause of death (Italy 232) They Privalley ROAD TIMONIUM, 18 31. Date filed (Month, Day, Year) SEP 2 0 32. Régistrar's Signature State 2008 Registrar

5:55

SEPTEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12, 20a-c per th g883 9-20-08 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No 2 1 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 15, 2008 **Physician** 10:10 P.M September William Alfred Gakenheimer, M.D. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County 611 St. Francis Road Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** August 03,1924 Baltimore, MD. Months Days Hours f&NM 2□ F 84 216-18-3863 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Baltimore County Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 611 St. Francis Road 21286 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? III 1 Xes 2 Note Can If Yes, Give Contilication 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White δ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 08 Physician Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Frederick Gakenheimer Jennie Matilda Meisle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heath ar
Important: If item 27 is
any Injury or other trau Mrs. Imogene G. Kluson (Daughter) 4903 4th Ave. Circle NW Bradenton, Florida 34209 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Place of Disposition (Ivaline Charles Park to the Charles Park to the Charles Date 20c. Location - City or Town, State Baltimore Maryland 9-19-2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieensee <sup>22. Name and Address of Facility</sup>
eaceful Alternatives Funeral&Cremation Ctr.,P.A.
2325 York Road Timonium, Maryland 21093 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Senile Vementia Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pertension certificate To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation Injury within 24 hours after users. After the Funeral Director: After the funeral by the funeral properties of the funeral proper 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D57444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Alexander

SEP 20

31. Date filed (Month, Day, Year)

Box 19099

Towson, MD 21284

MO

Registrar's Signature

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2008

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

Director

Funeral

Completed by

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours is Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; c any injury or other traumatic event, the Medical Exar any injury or other traumatic event, the Medical Exar any injury or other traumatic event, the Medical Exar

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To the Funeral Di

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Division or Vital Records, P.O. Box 68760, 6

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allolli	27. Man of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describ	e how injury	occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fa fy)	actory, office	28f. Location City or	(Street and Town, State)	i Number or Rural Route Number,	
anical	29a. Certifier 1 ertifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occu ation and/or investig	irred at the time, date and plac ation, in my opinion, death occ	e, and due to the time	ne cause(s) ne, date and	and manner as stated. place, and due to the cause(s)	
Ä	29b. Signature and title of certifier			29c. License number		29d. Date	e signed (Month, Day, Year)	
	I tal (	Tipon MD		D61785		9,	118/08	

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State

Registrar

ther Blud, Parlville, MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

SEP 2 2 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 106 a M 15,2008 Prince Herbert 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Baltimore Maryland General NA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Months Days Hours 1 ₩ M 2 □ F 219-50-3804 2-10-1948 60 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1∏Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1609 N. Chapel Street 21213 SA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th grade N/A Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richardson James <u> Irene Hill</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Bellamy-Aunt 1612 E. Madison Street Balto, MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-19-2008 Greenmount Cem Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): PINEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ACQUIRED IMMUNO DEFECIENCY Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Examiner requires that the death certificate be executed and burial-trar Box 68760, attending physician the as use j P.0. the detached ρ signed to Division of Vital Records, page 2 should has been this certificate Hospital or Attending Physician;

Examiner Certification: death. Director: in by the 24 hours after of Euneral Director of Euneral Director of Euneral Director of Euneral Director of European Euro

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/Medical

Examiner

Director

Funeral

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**Funeral** 

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Experience is set to notified at

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

3 🗌 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

2

Medical the ٥

State Registrar 6 □Could not be

Month, Day, Year) 32. Registrar's Ignatur 2008

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Merital Hydrene Certificate of Death

Reg. No. 1 - State Registrar Reg. No. 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 07:55 AM HARRIS EVERETTE AUGUST 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAYVIEW HOSPITAL BALTIMORE CITY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (0.28.1474 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Days Hours 1 M 2 F 34 219-17-4371 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nd other than "natural", or items 23a or 28a-f show event, if a Medical Examiner must be muffled at 1 ☐Yes 2 ☐ Mo Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21234 8431 Nater Oak Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 □ Yes 2 **□ ★**6 Specify: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: if item 27 is marked other this and hijury or other traumatic event, if all once. Transportation driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jandric Pauline Armstrong Harris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8431 Water ack Rd Baltimore MD 21234

De of Disposition (Name of page 102)

102 (02)

103 (02)

104 (02)

105 (03) auline 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 09/02/2008 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley 1-4-2000 Daltimore 22. Name and Address of Facility Valley C. Greene Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jaughn C 4905 York Ad Baltimore, My 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FIBRILL ATION 3 HOURS VENTRICULAR /Medical Due to (or as a consequence of) **Examiner** NONISCHEMIC 2 MONTHS CARDIDMYODATH Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' certificate 1X Yes 2 No 25. Was case referred to medical examiner? \_\_ Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funerai 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 AUGUST 26, 2008 shaline Rao, MEDICAL DUCTOR P-ES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE, BALTIMORE MARYLAND 21224 SHAUNE RAO : BAYVIEW HOSPITAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Amend 26,29d, perMD, g883 9/22/08 TT  State of Maryland / Department of Health and Mental Hygiene																	
			1 - State Registrar Certificate of Death								Reg. No 2008 30246						
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.37			CHARLOTTE ANN HALL A.K.A.				TINA HALLER				Septem	ber	13 20	80	10:58	a <sup>M</sup>	
	Examir	er	4a. Facility Name (If not institution,					y, Town, or		of Death		40	c. County of I				
	Funcial		MARYLAND GENERAL HOSPITAL - ER  5. Social Security Number   6. Sex   7. Age (In yrs. las							nder 24 Hrs. 8, Date of Bir			N/ 9.	Birthpla	ace (State or F	oreign	
	Funeral Director		295-48-6564 1 M 2 XF 5			Yrs	Month	s Days	Hours	Min.	(Month, D JAN 29	ay, Year) Co		Couintr ENTU	y)		
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Director	MARYLAND N/A  10e. Street and Number			BALTIMORE  10f. Zip Code						10a. C	itizen of Wha	zen of What Country?			
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Jar			19a. Informant's Name/Relationsh	ip (Турө. Print)		19b. Ma	iiling Addre	ss (Street	and Numb	er or Rur	al Route Num	ber, City	or Town, Sta	ite, Zip (	Code)		
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	744		23a. Part T. Enter the disease, or shock, or heart failure. List of	complications that cau	sed the death	n. Do not e						arrest,			Approximate Interval Between	een	
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	/Medical Examiner																
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ita	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Be C	ou 25 was case?  26. Place of Death (Check only one)														
7		To	1 DYes 2 No No Nospital: 1 Inpatient 2 ER/Outpatient 3 DOOA Other: 4 Nursing Home 5 Description									6 ☐Other (Specify)					
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	the Ho in 24 the Fu	Medical	(Check only cne) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
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	Regist	rar	CED 2. 2.	2008	gistrar's Signa	J. 6	DEAL.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 515 Heitmann Ham Frederick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Alice MARKITHURSING Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex '. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Apr 26, Birthplace (State or Foreign Country) Funeral Days Hours 1 ₹ M 2 □ F 134-14-6404 1926 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21211 2195 Rockrose Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by 3 ☐ Widowed 4 X Divorced unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) painter unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2195 Rockrose Avenue Baltimore, MD 21211 Alice Manor Nursing Home Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state 21. Signature Funeral Service Licensee Ronal S. Wade 23a. Pani. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): ∡xaminer aller Sequentially list conditions, if any leading to infrared cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed use as the bunal-transit and Due to (or as a consequence of): physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) be detached 1 ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform certificate 1□ Yes 2☑No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 | Yes 2 | 1 | No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury (Month, Day Year) 1 Natural 5 Pending death. investigation 2 Accident M 1 Yes 2 No within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifies ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D31464 Û 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760.

821 egistrar's Signature EM Mon A Ant 308

Ballmax MD21201

Pleased Type or Print in Black Indelible lak. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 208 **Physician** Month Sworth ! 1:40 PM EMMA (tuoson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tospice Kitchie nonin If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) Social Security Number 87 6. Sex 7. Age Ha yrs last birthday) **Funeral** 1 □ M 2 🕱 F Director onth Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experiment austice notified at 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status filed within 72 hours after 1 ☐Yes 2.☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2774No Specify: \$ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Indust (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tod man Pages 1 and 2 should I nent of Health and Men vvan ပ 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau 122 WILLE MAR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State -08 4 Donation 5 Dother (Specify) mi 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Nangm. 21229 Wallace 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Director (or as a consequence of): Approximate Interval Between Onset and Death Physician ILNS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit Cause (Disease or Injurthat initiated events resulting in death) Last Due to (or as a consequence of). the attending physician hed for use as the buria Physician/Medical IF FEMALE: signed by the attendir 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗖 No 1 □ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospice Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1. Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 144715 mo 9.17.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature ST PAUL BAUT MAS 306 ALV 31. Date filed (Month, Day State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEFTEMBER Day 6 . ELYNYA 6:45P **Physician** Patrice Mary Hesselbein /Medical 4c. County of Death . 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Joseph Medical Center 9. Birthplace (State or Foreign Country) Baltimore, MD. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 13,1961 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□M 2ÅF 218-88-7905 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examinar must be notified at 1 □ Yes 2 No Director Fallston Maryland Harford County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21047 United States 2202 Hampshire Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2**XXX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White \$ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Insurance Agent Long & Foster 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Betty Mae Anderson Jerome Francis Noyes ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2202 Hampshire Drive Fallston, Maryland (Mother) Mrs. Betty Mae Noyes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Sept. 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel: Forrest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Light on Ctr.,P.A 21093 Peacerul Alternatives Funeral&Cremation 2325 York Road Timonium, Maryland 210 21. Signature or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only drie cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA OF THE PANCREAS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Etile to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Division Natural 2 Accident 5 ☐ Pending investigation 1 □Yes 2 □No death. after death Director: d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 16,2008 Helou, M.D. D 0017695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) 32. Segistrar's Signature

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OSL

DRIVE TOWSON,

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death September 20, 2008 Physician ner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year 2.14.19 5. Social Security Number 6. Sex Age (In yrs. last birthday **Funeral** Months 1 □ M 2**X** F 219-38-7463 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland . City, Town or Location 10b. County 10a. State 28a-f show timore 1 Yes 2 ☐ No Funeral Director ?7 Is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 21216 mon 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ò 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DONOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) olyeurs. r's Name (First, Middle, Maiden Surnam 17\_Father's Name (First, Middle, Last) Be 2 Informant's Name/Relationship (Type. Pring 19b. Mailing Address (Street and mD 21228 atonsville, Health If item 27 5 Injury or other 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congesti **Physician** disease or condition resulting in death) /Medical Due to (or w a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit /a nding physician Box 68760, Physician/Medical use as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy detached for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Pregnant at time of death 5 Other (specify) P.O. ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 🗌 No 2 1 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 3 🗌 DOA 4 
Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient မ 28a. Date of Injury completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 4 Homicide 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 September 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adena Greenbaun 600 North Wolfe St, Baltimore, MD, 21287 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 22 

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiena Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 20, 2008 **Physician** 6:00 A RUTH HELD KUENNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County MANOR CARE, RUXTON NURSING CENTER Towson If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖫 F 102 Apr 6, 1906 217-48-1679 West Virginia Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b Counts 10a State ir than "natural", or Items 23a or 28a-f show the Modical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Baltimore 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21212 7 Goodale Place Be Completed by Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 l Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Residence Homemaker 12 17. Father's Name (First, Middle, Last) other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) and Mental h Charles William Held Elsie Mae Phipos 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 7 Goodale Place, Baltimore, Maryland 21212 Ms. Elsie Kuenne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Loudon Park Cemetery 9/24/2008 Baltimore, Maryland 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212
Approximately agreed.
Approximately agreed. 21. Signature of Fungral Service Cicers de Wartin D. Lawson Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Debilit MonThs **Physician** disease or condition resulting in death) /Medical Due to (or as a compequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day ö 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 deatn? 1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 s after death.

A Director: After this ed in by the funeral d this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier Sept, 20, 2008 DO06 11 99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 209, Touson MD 21204 6565 North Charles St Jason Black. 31. Date filed (Month, Day, Year) 32. Registrar's Signature boards State SEP 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#18, perFH, G883, 9/22/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:20P M KOLYADA SEPTEMBER 16 2008 **FEDOR** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE REISTERSTOWN FUTURE CARE CHERRYWOOD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F 219-57-0455 71 06/01/1937 RUSSIA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In "Medical Exercity", in the North of any Injury or other traumatic event, In "Medical Exercity", in the North of any Injury or other traumatic event, In "Medical Exercity", Inc. of the Injury of the Injury or other traumatic event, In "Medical Exercity", Injury or other traumatic event, Injury or other event. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location N/A 1X Yes 2 □ No Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 **USA** 5900 PARK HEIGHTS AVE., #208 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MINER MINING 18. Mother's Name (First, Middle, Maiden Surgeme) 17. Father's Name (First, Middle, Last) Be VASILIY KOLYADA MARINA မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SVETLANA MULLER / DAUGHTER PFARRSTRASSE 31 KASSEL, GERMANY 34123 20b. Place of Disposition (Name of ARIC NOTE) OF STREET PLACE (NAME OF STREET) 20c. Location - City or Town, State 20a. Method of Disposition Date N Burial 2 ☐ Cremation 3 ☐ Removal from State 9/19/2008 BALTIMORE, MD 4 ☐ Donation , 5 ☐ Other (Specify) AMUNO CONGREGATION 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as carding or respiratory arrest, shock, or heart failure. List only one cause or each in . Immediate Cause (Final disease or condition resulting in death) Di Seaso Physician 1 m Common /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be exacuted Exami Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant penditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title 29d. Date signed (Month, Day, Year) certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

1838 Greene Tree Pu 21208

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

		-	State of Marylan  State of Marylan  Registrar		artment of H rtificate of L			ne <sub>No.</sub> 2008	30253			
Ю	8	_	Decedent's Name (First, Middle, Last)			- 2	2. Date of Death Month		3. Time of Death			
10%	Physicia /Medic	al	Athena		Kropp	S		r17,2008	9:05 A <sup>™</sup> .			
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of Death				
	Ý.		1002 Downing Court  5. Social Security Number   6. Sex   7. Age (In yrs.	last hirthday	Be If Under 1 Year	1 Air	B. Date of Birth	Har for c	ce (State or Foreign			
东	Funeral Director		5. Social Security Number 6. Sex 1 M 2 7. Age (In yrs. 1 3 3 4 5 5 3	Yrs.	Months Days	Hours Min.	$\operatorname{Feb.6,1}^{Month,Day,Ye}$	955 Mary	land			
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	ne Ma 8a-f s otifiec	ecto			10f. Zip Code		10g.	. Citizen of What Countr	v?			
	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. As them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 1002 Downing Court		21014	, +		U.S.A				
		nera	11 Marital Status 12. Was Decedent Ever in U	J.S. 13.1		ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No-	14. Race - America				
36	irs after o	by Fur	Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:	ican, etc.,	Specify: Whit				
Maryland 21215-0036	72 hou natura ical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation during most of working ()	g   16	b. Kind of Business/Indu	ustry			
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aryl	2 should and Men is marke aumatic	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rural	Route Number, C	City or Town, State, Zip C	Code)			
	1 and 2 Health a tem 27 is		Steven Kropp (Husband)				Bel Air	, Marylan	d 21014_			
ore	Jes 1 of He or oth		14 Ruriol 2 Cromation 3 Removal from State	cemetery, crei	osition (Name of matory or other plac	ce)		c. Location - City or Tov				
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Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	1	201 Dun	dalk Ave	. Balti	i Funeral imore, Md				
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0,0	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a conse	quence of):								
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9	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome pf pregi				23d. Date of delivery					
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alF			OF Management to medical			26. Place of Death	1  Yes 2	No 1 □Yes	2 No			
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	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier  (Check only one)  1X Certifying Physician: To the best of my k  2  Medical Examiner: On the basis of examiner and manner stated.	nowledge, dea nation and/or i	nth occurred at the t nvestigation, in my	ime, date and place, opinion, death occurr	and due to the car ed at the time, da	use(s) and manner as si te and place, and due to	tated. the cause(s)			
	To the Within To the	Me	29b. Signature and title of certifier		29c. Licen:		29	d. Date signed (Month,	Day, Year)			
	/		MO MO		03	7517	S	eptember	18, 2008			
	'n		30. Name and address of person who completed cause of death (It	em 23a) (Type	e, Print)	1 -			21014			
			D. David C. Rubin, M. D. 5  31. Date filed (Month, Day, Year)  32. Agistrar's Signary	ZU Upp	per Ches	ареаке 1	orive S	uice Zuib	erair, Md.			
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 2 2008 32. Tegistrar's Sig	H A	pere							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 17:50PM RALPH LEES SEPTEMBER 18 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital Baltimore City | Houder 1 Year | Houder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 02-26-1937 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 71 Yrs. 5. Social Security Number 6. Sex 1 💢 M 2 🗆 F Ohio 289-32-9019 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Tes 2 No Bonita Springs Lee 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 34135 9840 Alhambra Lane U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11 Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 X No 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Plastic Injection College (1-4 or 5+) Elementary/Secondary (0-12) Molding Industry Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul E. Lees Dorothy Clarke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9840 Alhambra Lane, Bonita Springs, FL Ann Lees / Wife 34135 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hilltop Service Corp. 09-20-2008 | Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. 1050 York Road, Towson, MD Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest CRITICAL AORTIC STENOSIS YEAR Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

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**Funeral** 

Director

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Pages 1

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Baltimore, Maryland 21215-0036

burial-transi nding physician a use as the burial the signed by has filled in by the funeral director, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur

law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Physiclan;

or Attending

23a. Part 1 Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PERIPHERAL 2 No 3 Probably 4 Unknown VASCULAR DISEASE 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of eath 1 Natural 2 Accident 28a Date of Injury 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deciding Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manners and manner stated. Medical (check only

State Registrar

31. Date filed (Month, Day, Year) SEP 2

AFSHAR

29b. Signature and title of certifier

KIA



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

RES-000

29d. Date signed (Month, Day, Year)

18,2008

SEPTEMBER

29c. License number

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 9:45 a M Lorraine R. Lyons September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Oak Crest 9. Birthplace (State or Foreign Country) Washington DC 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 ☐ M 2 🛛 F 577-22-8209 **B7** 1921 Jan. 26, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Baltimore 1 ☐ Yes 2 ☑ No Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 21234 BBOO Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edwina Meyd John G. Reckert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lorraine Tishey/ Daughter 8335 Dubbs Dr. Severn, Md. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Md. 9-20-08 Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fineral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a conseque of): lend stage disease or condition resulting in death) stage cerebrounscular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □ Yes 2 **N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

9:45 AM

To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,

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State Registrar

**Physician** 

/Medical

Examiner

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a, Certifier

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evaluation to the traumatic event, I'm Medical Evaluation to the provided at once.

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0036

determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vixon

8CO Us IHer 32. Registrate Signature

BRUNE Perkulle, MP 2/234

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 48 pM **Physician** 18 2008 Paul N. Mangione /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale Baltimore FRANKLIN Square Hospital Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6-26-1932 **Funeral** 1**X** M 2□ F Months Days Hours Min. Md. Director 76 218-28-6806 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evandher must be a Liffed at once. 1 ☐ Yes 2 No Director Perry Hall Md. Balto. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21128 USA 9511 Kingscroft Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1▼DYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 □Yes 2X No White Specify. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Lighting Supply 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Felicia C. Coppolino Nicholas Mangione ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9511 Kingscroft Terrace Perry Hall, Md. 21128 Joyce G. Mangione Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 17 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-23-2008 St. Stanislaus Balto. 22. Name and Address of Facility Schimun ek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 23a. Par 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. and enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** a. Pulseless electrical disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Arrythmia VenTricular ardiac Fire countingly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner nd STage C Due to (or as a consequence of) cardiomyopathy physician and s the burial-trans resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient After this c funeral dire 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN Square DR Baltimore 21237 DR Burak K 9000 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 22 2008 Registrar

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

death with the Maryland

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21215-0036

Baltimore, Maryland

Mang10n

Harford

Country)

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

40415

Year

Ten

Dav

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

23d. Date of delivery

Month

1 ☐ Yes 2 X No

North Carolina

White

3. Time of Death 9:30A

USA

14. Race - American Indian,

Black, White, etc.

4c. County of Death

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) SEP 2 2 200 State Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1State of Maryland / Opportment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, Lillian May Day Majer Physician May Lilliam -Majer per 21.2.008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Samaritai 8. Date of Birth (Month, Day, Year) 01/15/1927 6. Sex 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. 1 □ M 2 12 1 216-20-5927 81 Maryland Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or Items 23a or 28a-f shedeal Examiner must be notified 1 ☐ Yes 2XXNo Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 305 North Marlyn Avenue U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or Ite 1 ☐ Never Married XX Married Marýland 21215-0036 1 ☐ Yes XXNo Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Elbert Ballentine Amelia Bobart ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Rolf (Daughter) 2003-L Magnolia Woods Court, Edgewood, Md. 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages XX Burial 2 Cremation 3 Removal from State 09/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 22. Name and Address of Facility.
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final dise and or condition residing in death) **Physician** TULMONAR /Medical Due to (or as a consequence of) **Examiner** VTERSTITIAL Sequet tally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Tyes 2 TNo 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy oerforme To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this the funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be within 24 hours after de

To the Funeral Directo

completely filled in by the 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number SICIAN

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

M.D. 5601 LOCH KAVEN
Year) 32 Begistrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 6:15 p M William 16 2008 Mondowney 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Baltimore N/A If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **½**M 2□ F 70 212-36-2099 1-23-1938 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County TYTYes 2 No MD N/ABaltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? N.Patterson Park Avenue 18 21213

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) S A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 🙀 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City of Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Mondowney Naomi Trusty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline A. Burrows-Niece 1303 Walters Avenue Balto, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Pk 9-22-2008 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H tadde 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Blech 242 Due to (or as a consequence mylestrick evenocoronus, ukrom Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery 3 □Ectopic pregnancy leath Day Year ath 5 ☐ Other (specify) Yes 2 🗆 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsv performed? Yes 2 20No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? V Josny 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide

**Physician** /Medical **Examiner** Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

Box 68760.

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Records,

Vital

or Attending Physician:

After this

Director:

24 hours a

To the

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

"natural", or

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other i ary Injury or other traumatic event, ti

Baltimore,

Director

Funeral

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Completed

Be ၉

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

FEMALE:	23c. If yes, outcome pf pregnand
3b. Was decedent pregnant	1 ☐ Live birth 2 ☐ Fetal of
in the past 12 months?	4 Pregnant at time of dea

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No 27. Manner of Death

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MA derm

29c. License number 3090-

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. W.

Hospu

State Registrar

Miches

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 9:38 PM Clarke Murphy Jr. September 18. 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson | Months | Days | Hours | Min. | August 16,1921 Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F Maryland 140-10-5673 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2XXNo Baltimore Towson Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 1908 Indian Head Rd. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 □Yes 2 No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ attorney private practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Hanlon James Clarke Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Indian Head Rd. Towson, MD 21204 Sarah W. Murphy/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory | Sep. 19,2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mitchell-Wiedereld Funeral Home, Inc. 6500 York Rd. Baltimore, MD rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION disease or condition resulting in death) CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery nt 3 Ectopic pregnancy Day Year 5 Other (specify) enditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ADVANCED DEMENTIA 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Be Completed

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, in a find let it a must be rediffed at

Maryland 21215-0036

Baltimore,

Pages 1 and 2 Health a

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ō Department of Important; If any Injury or

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Be Completed by Physician/Medical

Certification: To

Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, within 24 hours a To the Funeral D

IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 □Yes 2 □No 9 □ Unknown
Part II. Other significant co

		1 □Yes 2 MNo 1 □Yes 2 □No
25. Was case referred to medical examiner?		26. Place of Death (Check only one)
1 Yes 2 No	Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE
27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year) injury V	njury at 28d. Describe how injury occurred Nork? 1 □ Yes 2 □ No
3 Suicide 6 Could not be 4 Homicide determined		ce 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a, Certifier 1 M Certifying P	vsician: To the best of my knowledge, death occurred at the	ne time, date and place, and due to the cause(s) and manner as stated.

(Check only one)	2 Medicai Examiner:	6
29b. Signature and	d title of certifier	

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

D64395

SEPTEMBER 19, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MO 6545 N CHARLES ST, SUITE 209 BALTIMORE, MO 21204 32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of	Marylan		rtificate of		Mental Hyg	iene eg. No. 2	2008	30261	
	Physici	ian	Decedent's Name (First, Midd						Date of Deat     Month	th Day	Year	3. Time of Death	
	/Medi		Laura Virgin						Septemb	er 11		8 4:20 PM	
7	Examir	Dove House Hospice Westmins						or Location of Dea	th	4c. County of Death			
											rrol1		
B	Funeral Director		5. Social Security Number 217–28–7454	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Year Months Days			Vaarl	9. Birth Con Mar	nplace (State or Foreign untry) yland	
	and w		Usual Residence of Decedent  10a. State 10b. Count	,	10c Cit	y, Town or Lo	cation					10d. Inside City Limits	
	sho sho	'n		roll	100. 010		instér					1 ☐ Yes 2√ No	
	the N	ect	10e. Street and Number	1011		WESTIII	10f. Zip Code			0- 0:::	()40		
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	eath	era	11. Marital Status			S 13 1	Was Decedent of I		Specify Ves or No.	14	USA Race - Amer	ican Indian	
21215-0036	72 hours after o natural", or Iter dical Examiner	by Funeral Director	1 □ Never Married 2 □ Mai 3 ☑ Widowed 4 □ Divorced	If Ves Give	2 <b>X</b> No		If Yes, specify Cub 1 ☐ Yes 2 🗓 No		Specify Yes or No- rto Rican, etc.)		Black, White		
ŏ	2 hou	pe	15. Decede	nt's Education		16a. Dece	dent's Usual Occu	pation		16b. Kind o	of Business/I	ndustry	
215	within 7, iene. than "n he Medi	Completed by	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-	4or 5+)	(Give	kind of work done DO NOT use retire	during most of word)	orking			,	
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P	othe vent,	Be C	17. Father's Name (First, Middle	Last)				18. Mother's Na	me (First, Middle, I	Maiden Sur	rname)		
Maryland	Mental I	2	William Mumfo	rd				Carri	e Zepp				
ar	2 sho and I is ma		19a. Informant's Name/Relations						lural Route Number		wn, State, Z	ip Code)	
	and 2 ealth n 27		Charles Garver/son 121 Lumber Street Littelstown, P.								1734	0	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1							20c. Locati	20c. Location - City or Town, State		
Balt	permit. Departr Importa any inj		21. Signature of Funeral Service Licensee Ronald S. Wade. Director  Ronald S. Wade. Director  Raltimore, MD 21201									Street	
	1000		23a. Part   Enter the dise : e, o	r complications that ca	used the deat	h. Do not ent	er the mode of dyi	ng, such as cardia	or respiratory arre	est,		Approximate	
	Physician		Immediate Cause (Final	snoon or near failur. List only one cause on each line.  Interval E Onset ar sease or condition									
1	/Medical		resulting in death)	a. Due to (o	r as a conseq	uence of):	0					8/08-9/08	
6	Examiner												
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a conseq	uence of):							
	rificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	G									
Ó,	an al	Ä	resulting in death) Last	Due to (o	r as a conseq	uence of):							
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	rtifice ng ph as tl		IE ECMALC:	1							1		
Вох	The law requires that the death cert the has been signed by the attending age 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome pf pregna th 2 □ Feta		Ectopic pregnanc	v		23d.	Date of deliv	very	
). E	ed for	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (specify)	,			Month	Day Year	
P.0	that the de led by the detached	h	9 Unknown										
Ś	res tha signed be del	by	Part II. Other significant condition	ons contributing to dea	ath but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	/		the cause of death?	
ord	w requires been significant should to	bed							ع∠ا⊐1	≤ 2 N	o 3∏Pro	bably 4 ☐Unknown	
Records,	ne law r has be ge 2 sh	Completed							24a. Was ar		4b. Were aut	topsy findings available	
		no.							autops perform 1 Yes 2	ned?	death? 1 ☐ Yes	ompletion of cause of 2 ☐ No	
Vital	siclan: The certificate hir	Be C	25. Was case referred to medica examiner?	ıl				26. Place of De	ath (Check only one			2010	
or V	g: is:	To	1 Yes 2 No	Hospital: 1 ☐ In	patient 2	ER/Outpatien	t 3 DOA Oth		Home 5 ☐ Reside		Other (Spec	ity Pore Ha	
	ding Ph h. After th funeral		27. Manner of Death	28a. Date of	Injury , Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe ho			- Gre roug	
Ö	Attending r death. ector: After by the funer	atio	1 □ Natural 5 □ Pendir 2 □ Accident investi	gation	, 24, 754.7	, injury		Yes 2 □ No					
Division	r Atte	titic	3 Suicide 6 Could 4 Homicide determ	ained 286. Place C	of injury - At ho g, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Sti	reet and No	ımber or Rui	ral Route Number,	
	tal o	Certification:							City or Town				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Vertifyii	ng Physician: To the base	est of my kno	wledge, death	occurred at the ti	me, date and plac	e, and due to the ca	ause(s) and	manner as	stated.	
	the H in 24 he Fi plete	Medical	one)	Examiner: On the bas and manne	er stated.	mon and/or in	vesugation, in my	upinion, death occ	curred at the time, do	ate and pla	ce, and due	to the cause(s)	
	To the within 2 To the complete	Σ	29b. Signature and title of certifie	110	44 -	_	29c. Licens	se number	29	9d. Date si	gned (Month	, Day, Year)	
			- Ilokan	A Ku	Mi	1	Do	\$ 645	97	9	1101	(a)	
			30. Name and address of person	who completed cause	of death (Item	1 23a) (Type,							
			NOOST L. NIC	cmb 55	5 DX	th.	6360	street 1	woton	Star	MDo	2157	
	Sta Registr		31. Date filed (Month, Day, Year,	2008 Re	gistrar's Signa	pure April	West of the second						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UUS Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Day **Physician** 2008 1:00 am <u>September</u> Catheline /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rossville Baltimore Franklin Woods Nursing Center If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Year) 1 ☐ M 2 💢 F 2/22/1919 Maryland 216-32-4434 89 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ S. or Items 23a 21220 Α. 553 Compass Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 X Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other then College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bertha McCroby ပ Jessie Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other trea 361 Stillwater Road Marguerite Browning (Daughter) Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 9/25 W Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Deer Park, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Deer Park Cemetery 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee PA Essex, Maryland 21221 Sr. 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 Xo 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No CongeSTUE Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certified nun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Tom Edmondson 31. Date filed (Month, Day, Year)

28462

9105 Franklin

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar		aryland / Dep <i>Ce</i>	artment of rtificate of		F	Reg. No. 2008	3 30263
	Physici /Medi		1. Decedent's Name (First, Middle, La Dolores V. Neuhau	,				2. Date of Dea Month Septemb	Day Year	3. Time of Death  10:59 A <sup>M</sup>
100	Examir		4a. Facility Name (If not institution, given Stella Maris			Timonic			4c. County of Dea	<b>!</b>
	Funeral Director		5. Social Security Number 6. S 214-26-9050 Usual Residence of Decedent	Sex 7.Ag	e (In yrs. last birthday 78 Yrs.	Months Days			N Year) 9. Bir 30 Mar	thplace (State or Foreign ountry) 'YIand
	e Maryland sa-f show	ctor	MD 10b. County Baltimor	·e	10c. City, Town or L Baldwin	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the 23a or 2	Funeral Director	10e. Street and Number  5326 Sweet Air Ro			10f. Zip Code 21 01 3			USA	ountry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'v. Mcdcal Evariting a unce.	2	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐Yes 2 ☑! If Yes, Give Year or Dates:	No	1 □Yes 2√2 No	Specify:	Specify Yes or No- rto Rican, etc.)	Specify:	e, etc. hite
2121	ed within 72 lygiene. <b>ser than "nal</b> it, the Media	Completed	15. Decedent's E. (Specify only highest gra	completed) College (1-4or 5	(Give	DO NOT use retire	during most of wo		Restaurant	•
ryland	hould be filk and Mental H marked oth matic even	To Be	17. Father's Name (First, Middle, Last, Joseph M. Schnide  19a. Informant's Name/Relationship (	r	10b Mail	na Addrona (Stron	Hattie	M. Monto	,	Zia Coda)
Baltimore, Maryland	Pages 1 and 2 s nent of Health ar int: If item 27 is iry or other trau	5	Darleen N. Binns/  20a. Method of Disposition  **DBurial 2 Cremation 3 C	Daughter	3230 20b. Place of Dispondentery, cre	Dry Bran osition (Name of matory or other pla	ch Road	White Ha	all, Maryla 20c. Location - City or	nd 21161 Town, State
Baltim	permit. Pa Departmer Important: any Injury once.		4 Donation 5 Other (Specification of Funds) Service Licer		2	apel Cem 2. Name and Addr Ruck Tows	ess of Facility To	owson, Ma	Fallston, ryland 212 Inc. 1050	04
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CONDROS	ne.	ter the mode of dy	ing, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death
	rate be executed was hysician and inte burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Ind. This Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of): a consequence of):					
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	⊒ Ectopic pregnan ⊒ Other (s <i>pecify</i> ) <sub>-</sub>	су		23d. Date of de Month	livery Day Year
ords, F	w requires that been signed I should be det	by	Part II. Other significant conditions o	ontributing to death bu	ut not resulting in the u	nderlying cause gi	ven in Part I.		bacco use contribute to es 2 ☐ No 3 ☐ P	
		Completed				-		24a. Was a autops perford 1 ∐Yes	sy prior to med? death?	utopsy findings available completion of cause of 2 ☐ No
on of Vit	nysic nis ce direc	tion: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 X No  27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day	nt 2 ER/Outpatie	f 28c. Inju	ner: 4 🗆 Nursing I		ence 6 <b>X</b> I Other (Spe ow injury occurred	city) HOSPICE
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm, str c. (Specify)			28f. Location (S. City or Town	treet and Number or Ri n, State)	ural Route Number,
	the Hospi hin 24 hou the Funer mpletely fill	Medical	(Check only 2   Medical Exam	ysician: To the best on the basis of and manner sta	examination and/or in	vestigation, in my	opinion, death occ	urred at the time, d	cause(s) and manner a late and place, and due	to the cause(s)
D			29b. Signature and title of certifier  30. Name and address of person who	re V	path (Item 23a) (Type	29c. Licen	S 2 7	40	September 1991. Date signed (Mont	ben 9 1742
	Sta Registr	te	DR. ERNESTINE WI 31. Date filed (Month, Day, Year) SEP 2 2 2	32. <b>Registra</b>	0 DULANEY	,	O. TIMON	IIUM, MD	21093	

DHMH 17 Rev 1/2001

SEPTEMBER 18, 2008 10:59 a.m.

DOLORES NEUHAUSER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 1,24a,29a,30 per dr., 883,09/22/08dhb Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Leslie C. Year 8 Month **Physician** Day O /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2-25-1959 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. MARY LAND 217-82-0654 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show event, the Medical Examiner must be notified at MARYLAND Director 1 XYes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2547 FAIRMONT AVENUE 21223 Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐Yes 2 🕅 No Specify: BLACK à Specify: BLACK 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

PAINT MIXER Department of Health and Mental Hygiene. Important; If item 27 is marked other than 'any injury or other traumatic event, Inc. Maonce. Elementary/Secondary (0-12) College (1-4or 5+) PAINT FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental LESLIE COMBS OWENS, JR. RUTH HARCUM OWENS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH H. OWENS (MOTHER) 10656 MARY BALL ROAD LANCASTER VA. 22503 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State WILLIE CHAPEL CHURCH 9 13 2008 LANCASTER VIRGINIA 4☐ Donation 5 ☐ Other (Specify) Sign 22. Name and Address of Facility BERRY O. WADDY 6784 MARY BALL ROAD LANCASTER VIRGINIA 22503 23a. Part 1. Enter the shock, or hear disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause ( disease or condition resulting in death) inal Physician Confestive /Medical Due to (or as a consequence of) Examiner -5721 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner as a considuence of) that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Physician/Medical the as use a IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Vital 2 ANo 1 ☐ Yes or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA of After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3135 80 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda Washington, M.D., 2000 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP

240, 29n,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 22

2008

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of Marylan		artment of Health and M tificate of Death		iene 	30266
			Registrar  1. Decedent's Name (First, Middle, La	ast)	001	uncate of Boats	2. Date of Deat	h	3. Time of Death
	Physicia		Kenneth P	hillips			Month 09	Day Year 12 08	2316 pm
	/Medio Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or Location of Death		4c. County of Deat	h
			Eastern Correc	tional Institut	Hon	Westover		Somer	
	Funeral		1 1 40	Sex 7. Age (In yrs. 1⊠M 2□F ∠19	last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
	Director	-	220-36-4758 Usual Residence of Decedent	77	113.		November	2 73 1958 /74	ryland
	land ow	1	10a. State 10b. County	10c. Cir	ty, Town or Lo	cation			10d. Inside City Limits
	Mary -feh	ţō	Haryland WA	BA,	Himo	RE			1 XYes 2 □ No
	ours after death with the Maryland ral', or Nems 23a or 28e-f ehow Examirer must be rediffed at	Funeral Director	10e. Street and Number	-1-1		10f. Zip Code 2/2/8	1	Og. Citizen of What Co	ountry?
	ath wi	ral	1118 8, 28	HIEEF	- 1			14. Race - Ame	rican Indian
		nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	l.S.   13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
36	hours after tural', or Ite al Examire	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ② Divorced	ff Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		Specify: Aff	can American
21215-0036	"natural",	Completed	15. Decedent's E (Specify only highest gi	ducation	16a. Dece	dent's Usual Occupation kind of work done during most of work		16b. Kind of Business	Industry
218	- × 33	npie	Flementary/Secondary (0-12)	Coflege (1-4or 5+)	life.	DO NOT use retired)		6.16	alored.
	77 77	ပ်	17. Father's Name (First, Middle, Las	NA	Car	18 Mother's Nam	e (First, Middle, I	Maiden Sumame)	werka
and	ould be fi Mental H arkad ot atic ever	Be	Las Paris (Prist, Middle, Las	es Se		MARY	1	norton	
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 is markad othe other traumatic event.	ဥ	19a. Informant' Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street and Number or Rus	ral Route Jumber	City or Town, State,	Zip Code)
	alth ar 27 is		Kerdall Phill	ips SR -Son	1528	Shields Place	Dothi	nere, mil	21217
re,	of Health of Health fitem 27 r other tr		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place)		20c. Location - City or	Town, State
Ë	Page nent c int: if iry or		1 ☐ Burial 2 【Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec	ify)	Metre	a Crematory Septen	per 30	CATONSUI	
Baltimore,	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Lice	inse	2	2. Name and Address of Facility ANCU M. WAIII		C SCRUICE	, 21229
_	207 2 2		rayey m.	thelie	3	JOS W. FRANKIN S		Himore n	
				y one cause on each line.	th. Do not en	ter the mode of dying, such as cardiac	or respiratory arr	951,	Approximate Interval Between Onset and Death
	Pnysician /Medical	M	fmmediate Cause (Final disease or condition resulting in death)	a.METAST	T4T1	C PANCREA"	TIC C	ANCER	T Mo,
	Examiner			Due to (or as a consec	quence of):				
	3.33	-	Sequentially list conditions, if any, reading to immediate	b. Due to (or se a consec	quarios of):				
1	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immuniate cause. Enter Underlying Cause (Disease or injury that initiated events	c.					
٥,٠	cate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				
8760	cate be	dlcal		<b>d</b>					
9		- a	IF FEMALE:	23c. If yes, outcome of pregn	ancv			23d. Date of de	divery
Вох	eath certifii attending p for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
O.	t the de by the a tached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					
Ω.	The law requires that the death certificate has been signed by the attending to the 2 should be detached for use as	by Pi	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	inderlying cause given in Part I.		bacco use contribute t	
ď	w require been sig should b	edit	HEPATITIS	. C			1 🗆 Y	es 2.0⊡No 3.⊡P	robably 4 DUnknown
eco	law re as be 2 sho	Completed					24a. Was a	sy prior to	utopsy findings available completion of cause of
Ä		Соп					perfor 1 Tes	med? death? 2. No 1 ☐ Ye	
Vital Records,	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Othon	th (Check only or		POISON
of	Phys this al di	. To	1 Yes 2 No	I Inpatient 2L	28b. Time of	III 30 OOA 40 Maising /	ome 5 Resid	ence ther (Spa ow injury occurred	ecity) PRISON
on	ding h. After funer	tlon	1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	Injury	of 28c. Injury at Work?  M 1 Tyes 2 No		, ,	
Division	Attendir death.	ifica	3 Suicide 6 Could not	be 28e. Place of Injury - At h	nome, farm, st	reet, factory, office	28f. Location (S City or Tow	itreet and Number or F	Rural Route Number,
Ö	el or s afte et Dire	Certification:	4  Homicide determine	building, etc. (Speci	iry)		Only of 10W	ri, Glaloy	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying F	Physician: To the best of my kn	owledge, dea ation and/or in	th occurred at the time, date and place exestigation, in my opinion, death occurred	, and due to the o	cause(s) and manner a	s stated. e to the cause(s)
	To the H within 24 To the F complete	Medical	one)	and manner stated.				29d. Dalje signed (Mor	
	vit To	~	29b. Signature and title of contifier		1 D	29c. License number	4	9/12/26	)
				a completed opens of death (the	m 22a) /Tue-	D0025859		שוכוןי	
	\		DAVID me	o completed cause of death (ite チナ) イルら	-	Print) Eastern Correct Westover, MD	tional ] 21871	ınstitution	1
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	- Land	HODEOVEL / TID			
	Regist		CED 2 A	2008	M. 1	Seale 1			

DHMH 17 Rev 1/2001

ORIGINAL

30267

			1- State of Maryl Registrar		Department of F Certificate of a				30201
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of t	Death	2. Date of Dea		3. Time of Death
_	Physici Medic		Doris Emily Rigney				50 ntem	Day Year Dec 17, 2008	8:50 PM
	Examir Funeral Director		4a. Facility Name (If not institution, give street and number)  5. Social Security Number  214–18–9432  6. Sex  7. Age (In)  87	yrs. last birtl	Havro	r Location of Death  Property Control of Death  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day Sept. 3	4c. County of Death	
	and w		Usual Residence of Decedent  10a, State 10b, County 10c.	. City, Town	or Location			11	Od. Inside City Limits
	Maryla f shovied at	tor		el Air					1 ☐ Yes 2√ No
	h with the 23a or 28a st be notif	al Director	10e. Street and Number 555 S. Atwood Road		10f. Zip Code 21014		1	l 0g. Citizen of What Cour	ntry?
0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Wildowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	ecify Yes or No- Rican, etc.)		etc. White
215-(	nin 72 h n. "natu Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. I	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of worki d)	ing	16b. Kind of Business/In	dustry
212	ed with ygiene ier tha t, the I	Com	12		Secretary			State of Ma	aryland
land	should be fill and Mental H marked oth	To Be	17. Father's Name (First, Middle, Last) William Schaal			18. Mother's Name Madelin		,	
, Mary	and 2 shore ealth and N n 27 is ma		19a Informant's Name/Relationship (Type. Print) Alan Rigney (son)	90	8 Gainsboro	ugh Court		r, City or Town, State, Zipir, MD 210	
Baltimore, Maryland 21215-0036	Pages 1 ment of Hk ant: If Iten ury or oth		20a. Method of Disposition  1	b. Place of cemeters	Disposition (Name of y, crematory or other place ne Park	09/22		20c. Location - City or To Baltimore,	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signatur of Funeral Service License		22. Name and Address			Funeral Homer, MD 21014	
	Physicián /Medical Examiner	e	23a. Part1. Enter the disease or complications that caused the cance, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a condition failure)  Sequentially list conditions, if any, leading to immediate	Manusequence of Milh	<b>/</b>	ng, such as cardiac d	or respiratory arr	rest,	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (b) as a condition of the cond	isequence of		a disel	se		
P.O. Box	The law requires that the death certifite has been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pre 1 □ Live birth 2 □ If 4 □ Pregnant at time	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of delive Month	ery Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not	resulting in	the underlying cause giv	en in Part I.		bacco use contribute to to	
Vital Reco	sician: certifica rector, p	Be Completed	25. Was case referre to medical examiner?		politicate of Dogs Other	26. Plac f Death	Check onl on	prior to co death? 2 No 1 Yes	ppsy findings available mpletion of cause of 2 No
उट्ट	Ilng Phys	n: To	27. Manner of Death . 28a. Date of Injury	2 ER/Outp	patient 3 DOA	4 Mursing Ho		ence 6 Other (Specification of the control of the c	(y)
Id'n	or Attending after death. Director: After in by the funer	Certification:	2 Accident investigation	At home, far		Yes 2 ☐ No	28f. Location (Si	treet and Number or Rura	al Route Number,
Xo	Hospital 4 hours Funeral ely filled	Medical Cer	29a. Certifier (Check only one)  Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, mination and	, death occurred at the tir d/or investigation, in my c	me, date and place, ppinion, death occur	and due to the cred at the time, c	cause(s) and manner as s date and place, and due to	stated. o the cause(s)
	To the I within 2: To the I complet	Me	29b. Signature and title of certifier  W 5/M 9/M		29c. License	e number	2	29d. Date signed (Month,	Day, Year)
	ち		30. Name and address of person who completed cause of death (	(Item 23a) (T	Type, Print) W	MP6	mn	8 Kex 15	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature	rele				

Certificate of Death

2008

3. Time of Death

1:00

Birthplace (State or Foreign
Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

WEEKS

Year

1 ☐ Yes 2XXXNo

Baltimore

Italy

14. Race - American Indian, Black, White, etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Month

BALTIMORE, MD 21204

White

Specify:

P M

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Beatrice Rugolo Sept. 17, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** □ F Months Days Yrs. 219-40-2164 June 25, 1943 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Director Md. Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Summerfield Court 23a 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TWNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 → No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Restauranteur Food Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mario Varelli ပ္ Giuseppina Alvano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Mr. David Rugolo/Son 2515 Ebony Road Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Grd. 9/20/08 | Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician METASTATIC SMALL CELL LUNI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trans Due to (or as a consequence of) UGCIO, BEATRICE SQU Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EMPHYSEMA 1, XIYes 2 🗌 No. 3 🗀 Probably 4 🗀 Unknown Completed DIABETES 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident 1 ☐Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 164395 SEPTEMBER 17,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

DANKUE DOBERMAN, MA

31. Date filed (Month, Day, Year)

For State Registrar

32. Registrar's Signature

6565 N CHARLES ST. SWIE 209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.... 2. Date of Death 1. Degedent's Name (First, Middle, Last) Day Year Physician 09 200°6 /Medical 4c. County of Death Town, or L ocation of Death acility Name (If not institution, give street and number) Examiner More 8. Date of Birth (Month, Day, Year) NOV 1 1 196 Birthplace (State or Foreign Country) If Under 1 Year (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. M 2□ F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Exaction number notified at P Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Giv Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes Specify ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4or 5+) structus Elementary/Secondary (0-12) struction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 70 20b. Place of Disposition (Name of cemetery, crematory or other) Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Seemation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) elio M) 21. Sig atury of Funeral Service Licen ee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of disease, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) m Approximate Interval Between Onset and Death ing, such as cardiac or respiratory arrest, **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed physician and Due to (or as a consequence of): Physician/Medical the attending use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for 1 Month Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. Vital Records, þ 1 ☐ Yes 2 → 3 ☐ Probably 4 ☐ Unknown page 2 should peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 2 <del>□ N</del>o 1 □ Yes 2 **⊟**1√0 Physician: **Director:** After this certific d in by the funeral director, Was case examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🗖 No 1 hpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To oţ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No To the Hospital or Attendi within 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Funeral 1 Frifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie r's Signature 31. Date filed (Month, Day, Year, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) -Day 8 Month Physician September 2008 7:40 P M Annabelle Rigler /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) Feb. 5, 19 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF 213-18-8002 Yrs. 1921 Maryland 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tiem 21 is marked other then "nature!", or items 23e or 28e-f ehow any injury or other treumatic event, the Madical Examinar must the profiles at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 No Directo Union Bridge Carroll Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21791 U.S.A. 34 S. Main St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) sewing factory 11 seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah Wilhide William Mackley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Pigeon Hill Park Rd. Hanover, PA 17331 William H. Rigler III/ son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Union Bridge, MD 9/22/2008 \* 4 ☐ Donation 5 ☐ Other (Specify) Mountain View Cem. 21. Signatury of Funeral Service Lic 22. Name and Address of Facility Hartzler Funeral Home atharine Union Bridge, MD 21791 E. Broadway 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed the attending physician and the dor use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year certificate has been signed by the atterector, page 2 should be detached for Month Dav 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significan conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 @Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 24 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d, Describe how injury occurred Certification: After 1 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760

State Registrar

24 hours a Funerel I

within 2 To the

determined

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URNUS

4 Homicide

(Check only one)

29b. Signature and title of cert

31. Date filed (Month, Day, Year)

29a. Certifier

102

SULE

32. Registrar's Signature

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Cer	tificate of D	eath		Re	eg. No.	JUÖ	3021
Physicia	an/	Decedent's Name (First, Middle,La	ast)				2. Date of Deat	th	.	Time of Death
Medical Exami	ner	Barbara Mae Rad	lcliff					r 13, 2008		1713 hrs
		4a. Facility Name (if not institution, g Southern Maryland Hosp	,	1	City, Town, c .anham	or Location of Dea	ath	4c. County of Prince G		
, <del>-</del>			Sex 7. Age (In yrs. Ia		If Under 1 Ye	ear If Under 24h	dre 18 Date of Bir	th(MM/DD/YYYY)		lace (State or
Funeral Director					Months Da		lin.	`	Foreign V	Washington
			M 2 X F 5.	5 Yrs.			Feb 27	<b>,</b> 1953	Countr	ry) DC
any		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location					10	Od. Inside City Limits
<b>8</b> . I		MD Prince	George's	Upper Ma	r1boro				1	Yes 2 X No
Aaryland 28a-f show Lat once.	ę	10e. Street and Number			0f. Zip Code		1	0g. Citizen of Wha	at Country'	?
th the Maryland 23a or 28a-f sho notified at once.	Director	9009 Fairhaven A	Avenue		2	0772		USA		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once		11. Marital Status	12. Was Decedent Ever in U.	S. 13. Was E	ecedent of H	lispanic Origin? (	Specify Yes or No	- 14. Race	- American	n Indian, Black,
death or iten must b	Funeral	1 Never Married 2 Marrie	1 Voc 2 V No	If Yes,	specify Cuba	an, Mexican, Pue	rto Rican, etc.)	White	, etc.	
after (	by F	3 Widowed 4 X Divorce	or Dates:	1 Y	es 2 X N	o specify:		Specify:	whi	te
ours :	g p	15. Decedent's Education (Specify		16a. Decedent's		ation (Give kind of fe. DO NOT use it		16b. Kind of Bus	siness/Indu	ıstry
5-0036 led within 72 hours afte tlygiene. other than "natural", the Medical Examine	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Goming moon	or working in	0. 50 110 1 000 1	our ou)			
15-003 liled withi Hygiene. If other th	E	12 17. Father's Name (First, Middle, Las	5+	<u>la</u>	wyer	40 Mathada Ne	me (First, Middle, I	legal		
filed filed of the	Be C							<i>'</i>		
21215-0036 within 7 Mental Hygiene. marked other than cevent, the Medical	To B	Marshall Edmond 19a. Informant's Name/Relationship	and the first first contract of the contract o	19b. Mailing A	ddress (Stre		oel Carow		. State. Zu	n Code)
MD 21215-0036 d 2 should be filed within 72 tht and Mental Hygiene. n 27 is marked other than "		Edmond Radcliff	/brother				d Beltsvi		2070	
	- 1	20a. Method of Disposition	20b. F	Place of Disposition	n (Name of c		Date	20c. Location -		
nor ages ant of it: If		1 Burial 2 Cremation 3	Temoval Irom State	crematory or other	place)					
Baltimore, permit. Pages Lar Department of Hee Important: If ite injury or other tr	1	4 X Donation 5 Other Special Street Special Street Special Spe	ensee	22. Nan	ne and Addre	ss of Facility				
B P P F F	-	Konain S.	wad, Director	:  Stat	e Anai imore	tomy Boa MD 21	rd 655 W	. Baltim	ore S	Street
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on					c or respiratory arr	est, shock, or hea		Approximate Interval Between Onset and
/Medical Examiner	- 1	Immediate Cause (Final disease	a Atherosclerotic Cardiov	ascular Disea	se					Death
J.	- 1	or condition resulting in death)	Due to (or as a consequence of	f):						
	- l	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	f):						
	틀	cause. Enter Underlying Cause	C							
ed nsit	Examiner	events resulting in death) Last	Due to (or as a consequence of	ř):						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ca ·	UNPENDED	dAMENDED						-	
1760, ficate be exe g physician a	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pregr	ancy				23d. Date of	deliven	
387 rtifica ing pl	<u>اچ</u>	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3	Ectopic pre	gnancy	Month	Day	Year
Box 68 e death certif the attending	sici	1 Yes 2 No 9 ✔ Unknow	4 Pregnant at time of	5 Other	(Specify)			11/		
. Be the dery the a	اڅ	Part II. Other significant conditions	9 Olkilowii	aultina in the cond		sives in Deat I	220 Did to	obacco use contril	huto to the	cours of death?
cords, P.O. Box 68 aw requires that the death certif that been signed by the attending Should be detached for use as	2	Taren. Other significant conditions	contributing to death but not re	ssuling in the one	errying cause	given in Fait i.	1 Yes			ly 4 V Unknown
duires	Completed									osy findings available
COFC law re has be	헕						autop	osy p		npletion of cause of
1 of Vital Rec Jing Physician: The After this certificate funeral director, page	등						1 <b>Y</b> Yes		<b>✓</b> Yes	2 No
tal cian:	å	25. Was case referred to medical examiner?	Hospital:			Other				
n of Vil ing Physic After this funeral dir	유	1 ✓ Yes 2 No 27. Manner of Death	Inpatient 2 28a. Date of Injury	ER/Outpatient 3 28b. Time of Inju		jury at Work?	rsing Home 5	Residence 6 how injury occurre	Other:	
no Iding h. Aft	Ë	1 Natural 5 Pending	(Month, Day, Year)	200. Tittle of Inju		Yes 2 No	200. Describe	now injury occurre	5 <b>u</b>	
ivisior or Attend after death Director:	cat	2 Accident Investiga	ation 28e Place of Injury - At he	ome farm street			28f Location (	Street and Number	ar or Pural	Route Number, City
Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been si rely filled in by the funeral director, page 2 should b	Certification:	Suicide 6 Could no determin	ot be	and, rann, ou out,	idotory, omico	building, oto.	or Town, S		ii oi rtaiai	redic rember, ony
Hospi 4 hou Funer ely fil		20a Certifier	ician: To the best of my knowledg	ne, death occurred	at the time.	date and place, a	and due to the caus	se(s) and manner	as stated.	
To the Hospital within 24 hours To the Funeral Completely filled	Medical	1 - meen end	er: On the basis of examination are							
F × F 0	Me	29b. Signature and title of certifier	A. Mariner Stated.		29c. Licer	nse number		29d. Date signe	ed (Month,	, Day, Year)
		6/11/11	17	\	0.0	C.M.E.		September	14, 200	)8
	-	30. Name and address of person who	o completed cause of death (Item	23a) *						
	_		sistant Medical Examiner		Street, Ba	Itimore, MD	21201			
St Regist	ate	31. Date filed (Month, Day, Year) SEP 2 2	2008 32. Registrar's Signatu	re do	NE)					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 Perstate of Mary and Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year DAWAD SMITH F /Medical 1545 09 10 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CROSS HOSPITAL SPRING NER MONTGOME RY 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** 6. Sex If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 1 M M 2 □ F 31 Months 86 484 Director 140 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 23a or 28e-f show 10c. City, Town or Location Exactings must be notified at 10d. Inside City Limits Director WD ANNE ARUNDEL 1 Yes 2 □ No LAUREI 10e. Street and Number 10g. Citizen of What Country? SPADDER 20724 Funeral DOCK MACH USA items : 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 à 1 ☐ Yes 2 ☑ No 3 🗆 Widowed 4 🗆 Divorced "natural" Year or Dates: UNK BLACK Completed treumetic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNK UNK other MNK COMCAST 17. Father's Name (First, Middle, Last) Be n and Mental H 18. Mother's Name (First, Middle, Maiden Surname) NADE SMITH URNIJ SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tree HOLY CROSS HOSPIFAI 1500 FOREST GLENRO SILVER SPRING MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state Signature of Euneral Service Ronald icensee Wade State Anatomy Board 655 W. Baltimore Street a. Ph.1. Enter the discusse, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failtine. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or ndition resulting in death) Physician AIDS 4R /Medical Due to (or as a consequence of): Examiner APOSI SARCOMA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last YRS Examine Que to (or as a consequence of): the Hospitel or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit BNAL FALLURB Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, SP-PSIS Physician/Medical as IF FEMALE: esn 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery ò 3 Ectopic pregnancy ned by the a Month Year 5 Other (specify) Day 9 D Unknown 9 Unknown has been signed to 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? ANASARCA 1 🗌 Yes 3 Probably 4 Unknown certificete has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 **Z** No ours after death, erel Director: After this certific filled in by the funeral director, 1 ☐ Yes 20 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation M 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funereil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)
SEP 2 2 2008

BARBARA

Suparuch

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUPANIC

12. Redistrar's Signature Against GLEN RD SILVER SPRING MD 20910

RSM MD

D0065485

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:10 09-17-2008 Bruce Edward Suit /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** House of Jubilee Harford Fallston If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Min 1 X M 2 ☐ F 212-66-7813 51 02-27-1957 MD Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Director MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1946 Glenroth Drive Funeral 21009 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White b 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dentist Dental 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert L. Suit Virginia Ely 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. James L. Suit (Brother) 17821 Sandcastle Ct Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gar. 09-22-2008 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify)

**Physician** /Medical Examiner

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at

Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or Ite

or other traumatic

21. Signature of Funeral Service Licenses

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once.

Baltimore, Maryland 21215-0036

death with the Maryland

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Core i nome Passin 24000 disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗺 No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

22. Name and Address of Facility Schimunek Funeral Home of BelAir

Inc. 610 W. MacPhail Rd Bel Air, MD 21014

or Attending Physician: The law requires that the death certificate be executed the burial-tran Division or Vital Records, P.O. Box 68760名 attending physician this After death. after death the in by To the Hospital e within 24 hours at To the Funeral C Hospital

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Rosson

s. Roqueras

D 6053720

1200 # 106

September 1912, 2008

Below

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician JAMES** SPEARMAN 1010PM 16 2008 rotember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Lanham Prince Georges 5. Social Security Number 244-38-3376 8. Date of Birth 03-12-1925 If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1**X** M 2 □ F 83 Director Sampson County, NO Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits fshow 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Wedical Experience must be applied at MD Bowie Prince Georges ¥Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11208 Millers Terrace 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: timore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Private 12th pearman, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Spearman Ada Culbreth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mable Spearman Wife 11208 Millers Terrace, Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 Hillcrest Memorial Park Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/20/2008 Clinton, NC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MARYNGEA disease or condition resulting in death) /Medical ue to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and sthe burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hecords, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🍱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b 24a Was an autopsy performed? Yes 2 No certificate 1 ∐ Yes 1 ☐Yes 2 ☐ No of Vital Physician: this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division To the Hospital or Attending 5 Pending investigation 1 Matural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09/17/08 MDD 58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

CecilD. Georg

31. Date filed (Month, Day, Year)

SEP 2 2 2008

7500 Hanover

32. Registrar's Signature

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Parkway, SuitcloIA, Greenbelt, MD. 20770

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Shear Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If the Medical Evantire must be rediffied at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☒ Donation 5 ☐ O#			co	ace of Dispo metery, crer	sition (Name o natory or other	f place)	Date	•	20c. Loc	cation - City or	Town, State	
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 ☐ Cer (Check only 2 ☐ Me	rtifying Phy dical Exam	ysician: To the bes liner: On the basis and manner s	of examination	ledge, deatl on and/or in	occurred at the vestigation, in the contract of the contract o	ne time, date a my opinion, de	and place, and ath occurred	d due to the at the time,	cause(s) date and	and manner a place, and due	s stated. to the cause	e(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Facility Name (If not institution. give street and number) Examiner 4b. City, County of Death Town, or Location of Death (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Year) 1 □ M 2 2 € Months Days Min 62 Director rylan Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Wedford Exanting out Director 1 ☐ Yes 2 🗸 🍆 o ndSun 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 52 ()a 21241 Funeral Was Decedent Ever in U.S. Armed Forces?. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College,(1,4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Important; If item 27 is marke any injury or other traumatic ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) claughte Apt -4genia 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 1 Surial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility 23a. Put I. Enter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executer and burial-trar Due to (or as a consequence of): Box 68760, attending physician The law requires that the death certificate be Physician/Medical the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy or Month Year Day 5 Other (specify) P.0. the 9 Unknown 9 Unknow ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate perforr of Vital 2 No 1 □ Yes 1 □ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? mostren 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 1 ☐ Yes 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? After Division 5 Pending Injury safter death. 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

ddress o, person who completed ause of death (it

7 23a (Type, Print)

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egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g883 9-20-08 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Russell Shelton-Bey AKA Russell M. Shelton otember 1 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltinixe (14) General Hospital N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral X**□M 2□F Months Days Hours Min 212-48-0980 Director 1948 Maryland 29. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits Director Pikesville 1 ☐Yes 2X No Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21208 USA 7401 Monita Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐Yes &☐No δ Specify. 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. Private Industry Warehouseman permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other thi any fulury or other traumatic event, the gince. 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alberta Johnson Russell M. Shelton, Sr. 19a. Informant's Name/Relationship (Type. Print)
Joyce Simmons/ Sister 19b. Maijing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 21208 Monita Road Pikesviile, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Arbutus Memorial Park 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Arbutus,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service License 5240 Reisterstown Road Baltimore, Md21215 3a. Part 1. E. ver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Immediate Cause (Final sease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner lateral Deimonia Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dure to the expression one of The law requires that the death certificate be executed burial-t P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No g Unknown signed by t Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown icate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No certificate 1 ☐Yes 2 ☐No 1 ☐ Yes Attending Physician; 25. Was case referred to medical examiner?
11 Yes 2 \( \subseteq \text{No} \) director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dire 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 08 ause of death (Item 23a) (Type, Print) Jakyana

State Registrar 31. Date filed (Month, Day, Year,

32. Pojstrar's Signature

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Division of Vital Records, P.O. Box 68760

CLYDE TOLLEY

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To Be	1	Everett Tolley						walden Surname)					
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State Registrar 31. Date filed (Month Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



22257

HOSPITAL,

900 S. CATON AVENUE

BALTIMORE

ND-21229

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SFP

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 15. 19b per FH C884 10/6/08 TT

Amend Ttem 26,30, per dr. 1883 109/22/08dh Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 8 1 - For State Registrar 3028 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day geptember 10, 2008 Mae lliams lie /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Henrose altimore 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 2857659 Birthplace (State or Foreign Gountry) **Funeral** Months 1 □ M 2 😿 F 76 Yrs. 23 1932 Director Mary land 1167 March Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madical Examiner must be notified at Director Baltimore 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Penrose 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify. 2 3 Widowed 4 ☐ Divorced Specify: Blac Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Many injury or other event, Item Many injury or other traumatic event, Item Many injury or other event, Item Many inj Elementary/Secondary (0-12) College (1-4or 5+) Westen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be eona 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Tames Mcknight Brother 1548 Baltimore, Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNI 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemeter Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Howell 21 Sign ure of Funeral Service Licensee Funeral Home Ave, Baltime, MD 21207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No After this certificate has autopsy or Attending Physician: The 1 □ Yes 2 A funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Naccident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 ritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 884 30. Name and address of person who cause of death (Item 23a) (Type, Print) かり, 201 St. Paul Place, Balto.,MD 21202 m Arsna 31. Date filed (Month, Day, Year) SEP 2 2 2 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept. 2008 9:35 а.м CHARLOTTE HOFFMAN WHEELER 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore Gilchrist Center Baltimore 8. Date of Birth Month Day, Year) May 19, 1929 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M & XX Months Days Hours Min. Maryland 212-28-0851 79 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 🟋 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6451 North Charles Street 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2XXVo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2/CXNo Specify: White Specify: 3XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4 yrs. Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Lee Hoffman Martha Feast 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth C. Miller 111 8807 Watlington Road Richmond, Virginia 23229 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 9-22-08 Green Mount Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service L 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or conditions that caused the shock, or heart failure. List only one cause on each line. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC NON-SMAU CEU LUNI CANCEA disease or condition resulting in death) MONTH Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as only in the content of the con Doe to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 👿 Yes 2 🗌 No 3 🔲 Probably 4 🗍 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Directo

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau

Baltimore, Maryland 21215-0036

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physician and the burial-tran attending pl

Box 68760

of Vital Records, P.O.

Division

wheeler

certificate has been signed by the rector, page 2 should be detached director, this funeral After spital or Attendi ours after death. neral Director: A death. within 24 hours a

To the Funeral I

completely filled

Certification: To Medical

Physician/Medical Examiner ð Completed Be

10 State

Registrar

31. Date filed (Month, Day, Year)

4 Homicide

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

D64395

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

SEPTEMBER 20, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6565 N CHARLESST, SUITE 209 BALTIMONE, MB 21204

DANIEUE DOBERMAN, MO 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 4b,c,24a per dr Certificate of Death

Reg. No. Û 08 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical -Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Beltmare Randallstown Baltimore Q If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 1 □ M 2 🔼 Min. Months Days Hours 215-22-8372 10.20.1918 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, to blooking Examinar must be recitived at Baltimore 1 ☐ Yoo 2 ☐ No Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Graces موری را 2 should be filed within 72 hours after death v h and Mental Hygiene. 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 We Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: Specify \$ Specify: 3 ₩idowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12+0 *lerica* Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Brooks ည uth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an Nanette Widner Sposition (Name of rematory or other place)

Date

Date

Date

20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-18-2008 Baltimore, MD National 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Vaugno C. Oreene Funeral Services 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and dedetached for use as the burial-trans Due to (or as a consequence of) 6. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 certificate 2 No 1 □Yes 1 ☐ Yes Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Picture Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 N Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending Injury Within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the The the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) SEP 2 2 2008

SEP

Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 18 2008 YAGODA HERMAN 12:35A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BRIGHTON GARDENS OF PIKESVILLE PIKESVILLE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex Country) POLAND Months Days Hours Min 10X M 2□ F 81 382-28-9021 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1840 REISTERSTOWN ROAD 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: WHITE Specify: 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWNER RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) YAGODA ROSE BARUCH GAMER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3646 ELTHAM WAY, OWINGS MILLS, MD ELISE JOFFE / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 4 Donation 5 Dother (Specify) KING DAVID 09/19/2008 LAS VEGÁS, NV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Vie 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final thrombosis cerebral disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary 1 | Yes 2 | No 3 | Probably 4 X Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? Anemi 24a. Was an autopsy performe 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Chother (Specify) ASSISTED 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

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Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Examiner

Physician/Medical

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Be Completed

permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr.
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**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Funeral

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Completed

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Modical Expression must be notified at

Baltimore, Maryland 21215-0036

burial-transit the attending physician and the for use has certificate funeral director After 1

Division of Vital Records, P.O. Box 68760,

this To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by the completely

Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide t 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 20058676 Kaun L. Balritt M.D. September 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

State Registrar 31. Date filed (Month, Day, Year)

Karen L. Bayitt M. P.



4000 old court Road, suite 301 Baltimore, MD 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Dav Benjamin Wallace Allen :55P<sup>M</sup> /Medical 2008 Sept. 4. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 □ F Months Days Hours Min 578-36-0748 78 Director Dec 11. 1929 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Experience rust be notified at Director Maryland Prince George's Suitland [ ] Y∑Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a cm any injury or other traumatic event. 3112 Lassie Avenue Funeral 20746-3108 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 TyYes 2 □ No If Yes, Give Year or Dates: 1 □Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 2 College (1-4or 5+) vears Mail Carrier Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Benjamin W. Allen Lettie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine W. Allen - Wife 3112 Lassie Ave. Suitland, MD 20746-3108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 DOther (Specify) Maryland Vet's Cemt. Sept. 15, 2008 Cheltenham, MD 21. Six sture of Funeral Servi Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part It Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a sunsequence of): The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. **Other signific**an**t conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of al or Attending F after death. I Director: After d in by the funera 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated. (Check only one)

Division of Vital Records, P.O. Box 68760,

Registrar

31. Date filed (Month, Day, Year, SEP 0 9 2008

29b. Signature and title of certifier

30. Name and address of person who completed

cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar		artment of H			giene Reg. No/	2008	30286		
	Physici	an	1. Decedent's Name (First, Middle, La.	•				2. Date of De Month	ath Day		3. Time of Death		
4	/Medic	cal	Doris L. Adkin  4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of D		9 - 4 - 2008 1:13p				
1	LXGJIII	iei Ne.	Sunbridge Nurs	Elkton		Cecil							
	Funeral Director		5. Social Security Number 6. S 222-12-3152			If Under 1 Year Months Days	ff Under 24 Hours	Min. 10-5-	r.927	_ C	thplace (State or Foreign ountry) laware		
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits		
	a-f sh	ctor	DE New Ca	astle B	ear						1 ☐ Yes 2 ☑ No		
	vith the	by Funeral Director	10e. Street and Number 10f. Zip Code								0g. Citizen of What Country?		
	eath v		224 Benjamin B				19701  Was Decedent of Hispanic Origin? (Specifyes, specify Cuban, Mexican, Puerto R			USA			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Zi is marked other than "naturel", or Iteme 23e or 28e-f show morproment. If Item 27 is marked other than "naturel", or Iteme 23e or 28e-f show any injury or other traumatic event, the Medical Examinar mout be notified at once.	by Fun	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba	Specify:	Puerto Rican, etc.)		Black, Whit Specify: W	te, etc.		
S O	72 ho natur	Completed	15. Decedent's Ec	e completed) (Give		dent's Usual Occup	f working	16b. Kin	. Kind of Business/Industry				
121	within ane. than	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)			Datai	-		
9	filed Hygie Hygie other I	e Co	17. Father's Name (First, Middle, Last)	)	Admir	nistrati		sistant Name (First, Middle,		Retai. <sub>Sumame)</sub>	<u> </u>		
<u>la</u> n	Aental Aental rked tic ev	To Be	James Shaw				Sa	die Shar	rp				
Maryland	2 should be finance and Mental His marked of raumatic even		19a. Informant's Name/Relationship (	** *	19b. Mailir	Address (Street	and Number o	or Rural Route Numbe	ar, City or	Town, State,	Zip Code)		
ه ح	1 and Health em 27 ther t		David L. Adkin  20a. Method of Disposition			esition (Name of	LII DIV	d.Bear,		aware			
Baltimore,	Pages nent of I ant: If Ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cren	matory or other place remation	9-	9-2008		la, Pe			
	mit. F partme sorter / injur		21. Signature of Fundal Service Licen	4		S O 121 2. Name and Addres							
<u> </u>	Depa Depa Impo any ii		1 tout	t Juny	Be 20	eson Fu 53 Pula	neral ski H	Home of	New	vark rk.Del	aware19702		
	Physician /Medical Examiner	<b>3</b> C	23a-Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Approximate Interval Between Onset and Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death Interval Between Onset and Death Death Onset and Death Dea									
. Box 68760, death certificate be executed e attending physicien and id for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last  Due to (or as a consequence of):  d.											
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rds, P	quires that n signed b uld be deta	þ	Part fl. Other significant conditions of	ontributing to death but not res	buting to death but not resulting in the underlying cause given in Part I.				Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
Vital Records,	The law requires that the sele has been signed by the page 2 should be detached.	: To Be Completed						24a. Was autor perfo 1  Yes	osy ormed?	24b. Were a prior to death?	utopsy findings available completion of cause of		
/ita	ysician: Th		25. Was case referred to medical examiner?					Death Check only o	one				
On of ding Phya After this funeral di	Physic this c		1 ☐ Yes 2 ☐ No	Hospitaf:		Home 5 ☐ Residence 6 ☐ Other (Specify)							
	tending leath. tor: After the funer	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be		28b. Time of fnjury	M 1	/ at <br Yes 2 □ No	28d. Describe I					
	- 8 - 1		4 Homicide determined 288. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)					City or Tov	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital o within 24 hours alt To the Funerel Di completely filled in	edicai	29a. Certifier 1 ☐ Certifying Ph: (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death ation and/or inv	n occurred at the time vestigation, in my op-	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) a date and	and manner a: place, and du	s stated. e to the cause(s)		
	within To the comple	Me	29b. Signature and title of pertifier 29c. License								th, Day, Year)		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  S. S. Sachdes MD 118 North St Sink 3B Elle						9	9.4.08				
				holes MD	7/8 /\	Print) Joseph St	Sute	33 E	ek 6	n MD	12/92/		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registraffs Signal	ature	Sparle							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Z U U 8 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Sept. 2008 12:00 P<sup>M</sup> Ross A. Angelella /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice Care Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Months Days Hours 1X M 2□ F Pennsylvania **Director** 214 26 9942 Feb 12, 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Experience rout by notified at 1 ☐Yes 2 XNo Funeral Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9416 Parsley Drive 21042 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: White þ Year or Dates: 1940-45 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Many injury or other traumatic event, the Man once. Elementary/Secondary (0-12) 12 College (1-4or 5+) Sealy Mattress Co. Sales Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Crucifica Germano Sebastiano Angelella ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca W. Angelella/Wife 9416 Parsley Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 Cremation 3 Removal from State Crest Lawn Mem. Gard. 9-8-2008 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician JON Hod disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, terring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☑No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 PTNatural ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ber 4. 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles Fatto and 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 For State Registrar 30288 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 09 07 Vear 08 10:31 A M Margaret Estelle Apple /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 1□M 2√F Months Days Hours Yrs. Director October 12,1912 95 PΆ <u> 217-09-0949</u> Usual Residence of Decedent 10a. State 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 27 No PAFulton Warfordsburg permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any lijury or other traumatic event. The Experiment of thems 23a or any lijury or other traumatic event. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 200 Coonhollow Road 17267 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify:White þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Jacob E. Powell Harriett Hepler မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Stahle/Granddaughter 613 Maryland Avenue HaGERSTOWN, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Grove Cemetery 09/10/2008 Warfordsburg, PA 22. Name and Address of Facility 141 West Main Street Signature of Funeral Service Lio Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal dea 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy 1 ☐Yes 2 ☑No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 NO 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Ar completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State Registrar

31. Date filed (Month, Day, Year) SEP 2 2 2008

DR. Shiv Khanno

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

evale, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per State 38 Marylagd 68 enartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician Dorothy M. Barnett 500% PTEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTER MEDICAL CHARI NISIVL If Under 8. Date of Birth (Month, Day, July 6, 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 5. **321a9Se48×143193 Funeral** 1946 Hours 1 □ M 2 🕱 F Months Days Mary land 520-96-8651 Director 62 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ir items 23a or 28a-f shov 1 ☐ Yes 2 X No Director MD Charles Waldorf 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 20601 3017 Walnut Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☑ Married Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or i amy injury or other traumatic event, the "Mutcal Even" once. 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-003 \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Underwood Ashby Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BO17 Walnut Ln., Waldorf, MD 20601 Paul Barnett/ Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/08/2008 Waldorf, MD Trinity Mem. Gdns. 4 Donation 5 Dother (Specify) 22. Name and Address of Facilit Huntt Funeral Home 21. Signature of Funeral Service Licens 3035 Old Washington Rd., Waldorf, MD 20601 M01436 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ARRITUIMA 23 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of). or Attending Physician; The law requires that the death certificate be executed Examir 300BE AIN WIC attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 1 ☐ Yes 2 No 9 ☐ Unknown 0 9 Unknown ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s certificate 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Yes

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

08

			For State Registrar	State of Mar	•		t of H			giene Reg. No		00000	
	A		Registrar     Decedent's Name (First, Middle, Last	t)		imoui		-	2. Date of De	eath	2000	3. Time of Death	
3+1	Physicia	_	Dorothy Pearl Ba	rnett					Sept. (	Da	y Year 2008	7:15 A <sup>M</sup>	
9.5	/Medic Examin	-	4a. Facility Name (If not institution, give			4b. City	Town, or	Location of Death			County of Dea		
	5		Genesis of Waldor				dorf	Williaday Od Illian	To = 1 (=)		narles		
	Funeral		5. Social Security Number 6. S	ex 7.Age. □M 2DXF	(In yrs. last birthday) Q7 Yrs.	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Co	thplace (State or Foreign ountry)	
	Director	ž.	578-10-4283 Susual Residence of Decedent		97 Yrs.				04/26/	1911	Was	hington, DC	
	yland iow		10a. State 10b. County		10c. City, Town or Lo	cation						10d. Inside City Limits	
	a-f st	ctor	MD Charles		Waldorf							1 □Yes 2X No	
	or 28	Director	10e. Street and Number			10f. Zi	p Code			10g. Cit	izen of What Co	ountry?	
	s 23a	ral	3017 Walnut Lane	12. Was Decedent Ev	esin II C 12 1	206		enanio Origin? (S	nacify Vas or No	U.S.	A. 14. Race - Ame	erican Indian.	
396	72 hours after death with the Maryland 'ratural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 X No If Yes, Give Year or Dates:	)	was Dece If Yes, spo 1 ☐ Yes		spanic Origin? (S in, Mexican, Puert Specify:	o Rican, etc.)	,-	Black, Whi	te, etc.	
21215-0036	72 hou natura lical E	Completed	15. Decedent's Ec	ucation	16a. Dece	dent's Usi	al Occupa	ation during most of wor	rkina	16b. K	ind of Business	/Industry	
21	within 7 iene. than "r ie Med	lg .	Elementary/Secondary (0-12)	College (1-4or 5+	) } _		ise retired	during most of wor )	3	D-1			
	be filed within 72 hc Ital Hygiene. d other than "natu event, the Medical		10   17. Father's Name ( <i>First, Middle, Last)</i>		Secre	lary		18. Mother's Nar	me (First. Middle		(er's Ur	110n	
anc		Be c	William Edelin Wo					Annie Ar		,	, , , , , , , , , , , , , , , , , , , ,		
Maryland	nd 2 sho alth and 27 Is m r traum	욘	19a. Informant's Name/Relationship (		19b. Mailii	ng Addres				ber, City or Town, State, Zip Code)			
			Paul C. Barnett/	Son	3017	Waln	ut La	ne, Walc	orf. MD	_206	501		
ore,	es 1 and of Healt f Item 2 r other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cre-	osition (Na matory or	me of other plac	e)	Date	20c. L	ocation - City o		
ij	: Pages tment of tant: If It tant: or o		4 □ Donation 5 □ Other (Specif		Cedar Hi							ID .	
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21, Sign yure of june al Service Lice	Olives I	M01436 3			ss of Facility Hu				20601	
			23a. Part1. Enter the disease, or com	plications that caused t	he death. Do not en						IUTI , ML	Approximate Interval Between	
h.	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	TTVE	Jrz	ANS	1 (-03	JUN	Ne,		Onset and Death	
	Examiner			A Color as a	consequence :	17	30	sele	KN SI	5,		1-mars)	
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):	4						- 0	
	cate be executed physician and the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
30,	oe exe	Ě	resulting in death) Last	Due to (or as a	consequence of):								
68760,	phy:	dical		d									
)× 6		/Me	IF FEMALE:	23c. If yes, outcome p	f pregnancy						23d. Date of de	elivery	
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No	1□Live birth 2 4□Pregnant at t		⊒Ectopic ⊒Other (:	pregnancy specify)	′			Month	Day Year	
Ö	at the de by the a tached	hysi	9 Unknown	9□Unknown									
Records, P.	ss that	by	Part II. Other significant conditions	ontributing to death but	not resulting in the u	nderlying	cause give	en in Part I.			.1	to the cause of death?  Probably 4 Unknown	
00	aw require s been sig	Completed							24a. Wa		24b. Were a	autopsy findings available completion of cause of	
R	The lav	mo								opsy formed? 2 <b>I</b> N	death?	_	
ita		Be C	25. Was case referred to medical examiner?					26. Place of De		- 11			
or Vital	is dil	일	1 ☐ Yes 27 No	Hospital: 1 ☐ Inpatien				4 K Nursing I	Home 5□Res			ecify)	
o U	ing Affer une	in oi	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	of M	28c. Injur Work	yat k? Yes 2 ⊡No	28d. Describe	how inju	ury occurred		
Division	Attending r death. ector: After by the fune	icat	2 Accident investigatio 3 Suicide 6 Could not b	28e, Place of injur	y - At home, farm, st			Tes 2[]NO	28f. Location	(Street a	and Number or I	Rural Route Number,	
Di∧	tal or A s after al Dire ed in by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)				City or To	own, Sta	te)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	edical	29a. Certifier 1 CertifyIng Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner stat	examination and/or in	th occurre	ed at the tir	me, date and plac opinion, death occ	e, and due to the curred at the time	e cause( e, date a	s) and manner and place, and di	as stated. ue to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	1 An		2	9c. Licens	e number		29d. D	ate signed (Mo	nth, Day, Year)	
			Jun H1	Nall	W -	<u> </u>	1)2	065	9		4/6/	08	
(	Db2		30 Name and address of person who	completed cause of de	ath (Item 23a) (Type		· U	JALD	onr	M	0. 2	1603	
	Sta	ate	31. Date filed (Month, Day, Year)		r's Signature	rade	,	-					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Aate of Death 3. Time of Death **Physician** Bennie William Bowman /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Hours Days 250-32-6280 1₽ M 2□ F Director 83 1/30/1925 South Carolina Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Itsalical Extension mist be recitive at Director 1' Yes 2 No Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7857 Burnside Road 20785 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 △Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian 1 Never Married 2 Married If Yes, Give Year or Dates: Army by 1 □Yes XXNo specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Bowman ပ Isabella Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is Pages 1 and 2 8255 Spring Branch Court, Laurel, MD 20723 Henry Bowman/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/12/2008 Landover, MD Harmony Memorial 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funer | Service Licensee 7474 Landover Road, Landover, MD 20785 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician reymon resulting in death) /Medical Due to (or es e consequence of): Examiner SI Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 A No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes Certification: To 1 Department 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKOK GALLANT FOX LAWE 31. Date filed (Month, Day, Year) State SEP 0 9 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **9** Day **Physician** 6 2008 8:22 РМ James E. Beck /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1610 Baltimor Ave. Rm. 313 Ocean City Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 5/5/1942 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days XXM 2□F 168-34-8491 Director 66 Usual Residence of Decedent and 2 should be filed within 72 hours efter death with the Maryland ealth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show digal Examiner must be notified at 1 ☐ Yes 2 No Director PA Lancaster Ephrata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Woodchuck Dr. 17522 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes **②**(X)No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If frem 27 Is marked other the any Injury or other traumatic event, the one. Bank Auditor Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin S. Beck Wilda Faust 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Beck / wife 125 Woodchuck Dr., Ephrata, PA 17522 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lincoln Cemetery 9/12/2008 4 Donation 5 Dother (Specify) Ephrata, PA 21. Signature of Funeral Service 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part1. Enter the dises or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EW YEITZS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2D No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 25. Was case referred to medical examiner?
1 ☐ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA Hotel 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORTH, 203 SNOW ST. SMOUN HILL, MD, 21863 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 0 9 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 30293 For State Registrar Certificate of Death 2. Date of Death Month September 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 6, 2008 10:28 AM Ellen Burger 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death

**Physician** 

/Medical

**Examiner** 

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must be nutified at once.

Baltimore, Maryland 21215-0036

7	Physician
	Physician /Medical Examiner
DIVISION OF VITAL DECORDS, P.O. DOX 00/00,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Casey House					Rockvil				N	lontgo		
	5. Social Security Number	6. 5	Sex 1□M 2⊠F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2	24 Hrs. 8 Min.	B. Date of Birt (Month, Day OV • 12	h y, Year)_		Birthplace (Star Country)	te or Foreign
	187-28-7488		W ZEST	88	Yrs.			N	ov. 12	, 19	919 C	zech	
	Usual Residence of Decede			10c Cit	y, Town or Lo	cation						10d Inside	City Limits
'n		-											es 2 □ No
Be Completed by Funeral Director		tgome	ery	Roo	ckville								
	10e. Street and Number										izen of What	Country?	
ā	1799 East Je	ffer	son Stre	et	20853					U.	U.S.A.		
nue	11. Marital Status		12. Was Deced		S. 13. V	Was Decedent of F f Yes, specify Cub	lispanic Origan, Mexican	gin? (Speci	ify Yes or No- ican, etc.)		<ol> <li>Race - A Black, W</li> </ol>	merican Indian hite, etc.	,
Ϋ́	1 Never Married 2		1 ∐Yes :			1 □Yes 2 ☑ No					Crooiby.		
Q D	3 ☑ Widowed 4 ☐ Div	orced	Year or Da					<del></del>			<u> </u>	White	
ete	15. Dec (Specify only	cedent's Ed highest gra	ducation a <i>de completed)</i>		(Give	dent's Usual Occup kind of work done	during most	of working	,	16b. Ki	nd of Busine	ess/Industry	
ᇤ	Elementary/Secondary (0	-12)	College (1-	4or 5+)		DO NOT use retire	a)			_			
ပိ	8		,		Homen	naker			F:		Home		
Be	17. Father's Name (First, M.		)				18. Mothe	rs Name (	First, Middle,	Maiden	Surname)		
٩	Samuel Itzko	vitz					Cece	ila K	raus I	tzko	ovitz		_
	19a. Informant's Name/Rela	ationship (	(Type. Print)		19b. Mailin	ng Address (Street	and Numbe	er or Rural	Route Numbe	er, City o	r Town, Stat	te, Zip Code)	
	Carol Burger	: – Da	aughter			C South W		ock S	treet	Arli	ington	, VA 22	206
	20a. Method of Disposition	0.5	70	20b. F	lace of Disposemetery, cren	sition (Name of natory or other plac	ce)	Dat	te	20c. Lo	cation - City	or Town, State	
	1 ☑ Buriaì 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			tate		emetery		9/8/0	1 80	lew :	Burnsw	rick, NJ	ī
	21. Signature of Funeral Se	ervice Lice	nsee		22	Name and Addre	ss of Facility	у		1 01-	1-	T	
	10/	10	•		11	nzansky-0 70 Rockv	ille F	erg Me Pike	moria. Rockv	ille	apers,	20852	
	23a. Part1, Enter the disea	se, or com	plications that ea	used the deat							,	Approxir	nate
	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death												
	disease or condition End Stage Alzheimer's Dementia												
	Due to (or as a consequence of):												
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ni U	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Duc 10 (c	, as a conseq.	acrice or,.								
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Me	IF FEMALE:		23c. If yes, outc	ome of preama	incv								
ian	23b. Was decedent pregna in the past 12 months?		1 🗌 Live bi	rth 2 Feta	Ideath 3□	Ectopic pregnance	у				23d. Date of Month	Day	Year
/sic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown		4 ☐ Pregna 9 ☐ Unkno	ant at time of o wn	leath 5∟	Other (specify) _						,	
by Physician/Medical Examiner	Part II. Other significant co	nditions	contributing to dea	ath hut not resu	ulting in the ur	nderlying cause giv	en in Part I		23e Did to	phacco i	ise contribut	e to the cause	of death?
ò	Chronic Obst					, ,	ciriiri diti.					Probably 41	
ted	Onionic obse	. Luce	IVC I GIM	onary 1	7130430				''''			Triobably 41	A OTIKIOWII
Complete									24a. Was a		24b. Were	autopsy findin	gs available of cause of
, j									perfor	rmed?	deat		
Be (	25. Was case referred to m	edical					26. Place	of Death (	Check only or				
	examiner? 1 ☐ Yes 2 🔯 No		Hospital: 1 ☐ In	patient 2	ER/Outpatien	nt 3 DOA Oth	ier: 4 □ Nu	rsing Home	e 5 🗆 Resid	dence	6 ☑ Other (5	Specify)Hosi	oice
ä	27. Manner of Death		28a. Date o	f Injury o, Day, Year)	28b. Time of Injury	28c. Inju			d. Describe h				
atio	1 ☑ Natural 5 ☐ P 2 ☐ Accident ir	ending nvestigation		, Day, real)	injury		lYes 2 □	No					
<u>≅</u>		ould not b	28e. Place C	of Injury - At ho	me, farm, stre	eet, factory, office		28				r Rural Route N	lumber,
j.	4 Li Homicide		Duliging	g, etc. (Specif	V)				City or Tow	vn, State	)		
a	29a. Certifier 1 ☑ Ce	rtifying Ph	nysician: To the t	pest of my kno	wledge, death	occurred at the ti	me, date an	nd place, ar	nd due to the	cause(s	) and manne	er as stated.	
Medical Certification: To	(Check only 2 Me	dical Exa	miner: On the ba and manne	sis of examina	tion and/or inv	vestigation, in my	opinion, dea	th occurred	d at the time,	date and	d place, and	due to the caus	e(s)
Me	29b. Signature and title of c	ertifier	0			29c. Licens	se number			29d. Da	te signed (M	lonth, Day, Year	7)
	J. Kou	ecto	hou,	mis		200	637	48		Cont	omb a	6 200	٥
					22a\ /T !	Print\				sept	-ember	6, 200	O
	30. Name and address of pe					•	0 101	. D	1++	. 1	m 212	10	
	Jocelyne Kou 31. Date filed (Month, Day,		32 Re	distrar's Signa	ture 🎍	ersity P	arkwa	у ва	ltimor	e, M	m 717	10	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2008 10:10 A M Lorenz J. Brosnan September \_1 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 8260 H Stone Crop Drive Ellicott City Howard 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months 1**X** M 2□ F Days Hours Min. 75 Dec 10, 1932 120 26 6471 New York Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8260 H Stone Crop Drive 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xes. 2 □ No If Yes, Give Year or Dates: 1954–56 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Shimadzu College (1-4or 5+) Elementary/Secondary (0-12) 4 National Sales Manager Scientific Instruments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lorenz Brosnan Mary Maher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Brosnan/Wife 8260 H Stone Crop Drive Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 9-5-2008 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. m01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia Due to (o as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2∏ No 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760. P.O. Records, or Vital Division

that the death certificate be executed physician attending pt the signed by t peen Jas certificate this After Hospital or Attending death. Director: / hours after within 24 hours at To the Funeral D

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or Items 23a or 28a-f shoredical Examiner must be notified at

Medical

27 Is marked other than traumatic event, the Me

2 should be f and Mental H

permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any injury or other trau

**Physician** /Medical

Examiner

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Physician/Medical

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Certification:

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Baltimore, Maryland 21215-0036

Director

Funeral

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60

State Registrar

31. Date filed (Month, Day, Year) SEP 0.5 2008 DHMH 17 Rev 1/2001

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

JACOB CHERIAN

6 Could not be determined

JACOB CHERIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pagistrar's Signature 32.

6910

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

509

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Sept 2, 2008

			1 - For State Registrar	State of Ma	aryiariu	-	tificate of		Wellari	Reg. N	2008	30295			
	Physici	an	1. Decedent's Name (First, Middle, La	•					2. Date of D Month Sept.	eath		3. Time of Death			
1	/Medio		Ann Margaret Cla 4a. Facility Name (If not institution, gi				4b. City, Town, o	r Location of Dea	<del></del>		c, County of Deat	12:05 AM			
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ì	Funeral Director		1	Sex 7. Ag. 1 □ M 2 🛛 F	e (In yrs. las 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		7192	2 9. Birti	hplace (State or Foreign untry) 110rnia			
	yland how at		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits			
	he Mar 8a-f sl otified	ector	MD Calvert		St.	Leona						1 □Yes 2 □XNo			
	aa or 2	I Dir	10e. Street and Number 1321 Flag Harbor	Boulevard			10f. Zip Code 20685			-	citizen of What Co	untry?			
9	after death or items 2 miner mus	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1  Yes 200			Vas Decedent of H f Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue Specify:	(Specify Yes or Nerto Rican, etc.)		14. Race - Amei Black, White				
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	3  Widowed 4  Divorced  15. Decedent's E	Year or Dates:			lent's Usual Occup			16h	Specify: Wh Kind of Business/I	nite			
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121		To Be Con	17. Father's Name (First, Middle, Las	1		Secre	tary	18 Mother's Na	ame (First, Middle		Air Fo	orce			
lan			George Cooper	y				Callie		s, ivialue	an Surname)				
Maryland 21215-0036											ural Route Number, City or Town, State, Zip Code)				
ē,			20a. Method of Disposition	17 Daugittei					Date	-					
<u>m</u>			20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Huntt Crematory  20c. Location - City of Disposition (Name of cemetery, crematory or other place)  Huntt Crematory  09/08/2008 Waldorf, MI												
Baltimore,	permit. Departi Imports any inj		21. Signature of Funeral Service Lice		101436		Name and Addre					20601			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final												
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15	led sit	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  HYPER((PIDEH)A  Due to (or as a consequence of):													
oʻ	execuin and rial-tran	Exan	that initiated events resulting in death) Last	Due to (or as	a conseque					<u>-</u>					
68760,	tificate be executed g physician and as the burial-transit	ledical	CHF												
.O. Box 6	death cer e attendin d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes #□ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 □ Fetal d	eath 3□	Ectopic pregnancy Other (specify)	/			23d. Date of deli Month	very Day Year			
<u> </u>	ires that the de signed by the a be detached f	by Ph	Part II. Other significant conditions	contributing to death bu	ıt not resulti	ng in th <i>e</i> un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?			
ords	w require been sig should be								. 10	Yes :	2.⊡-Nó 3.∏Pro	obably 4 Unknown			
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Vital	ysiclar is certif director	o Be	25. Was case referred to medical examiner?  1 ☐ Yes	Hospital: 1 ☐ Inpatie	nt 2□FF	R/Outnatient	3□ DOA Oth		eath (Check only		6√ Other (Spec	ASSISTED			
Division or	ing Ph After th uneral	-y	27. Manner of Death  ↑ Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day	y 2	8b. Time of Injury	28c. İnjur Wor		28d. Describe			city) CTOING.			
DIVIS	ospital or Attend hours after death uneral Director: iy filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home . (Specify)	e, farm, stre	et, factory, office		28f. Location City or To			ral Route Number,			
	the Hospital	Medical	one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination	edge, death n and/or inv	estigation, in my o	pinion, death oc	curred at the time	, date a	nd place, and due	to the cause(s)			
)	To the vithin To the comple	2	29b. Signature and title of certifier  N. U	dono	MI	>		06063		9	ate signed (Month)	n, Day, Year)			
4	SB.5		30. Name and address of person who NAYANTAKA	completed cause of de (ENDONU		3a) (Type, F	,	ATIGEO	FREDER	AD		20678			
T.	Sta Registr		31. Date filed (Month, Day, Year)	2008 32. Projistra	r's Signatur	k de			- man an age - no						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 3, Physician 2008 10:32am M DAVID EARL COURMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours 1 ☑ M 2 ☐ F Days 49 NC 11/28/1958 Director 240-94-4149 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 ehror any injury or other traumatic event, the Medical Experiments on the property of 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1♥ Yes 2 No **Funeral Director** NC Craven New Bern 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 28560 2107 Opal Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2√2 Married Specify: Black 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Jessie Courman David Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2107 Opal St., New Bern, North Carolina 28560 Karen D Courman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Oscar's Mortuary 4 ☐ Donation 5 ☐ Other (Specify) 9/8/2008 New Bern, NC 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 Ninth Street, NW Washington, DC 20011 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metabolic days Physician /Medical associated Adult T-cell Cerkenia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably J ☐ Unknown 24a. Was an autopsy performed' 2 🗆 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29c. License number MD 03 4495 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANJEEVE BALASUBRAMANIAM 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 08 2008 Registrar

DHMH 17 Rev 1/2001

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 4 ZOOS **Physician** (ordel 155Z M lavid /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1**√** M 2 □ F 50 Michigan 12/17/57 **Director** 384-64-0423 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 1X Yes 2 ☐ No Director Md Prince George Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
unt: If Item 27 is marked other than "natural", or items 23a or USA 20772 13910 King George Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Black <u>م</u> 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State Government Auto Mechanic 2years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Chenault James Cordell ဂ္ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Virginia Cordell Wife 13910 King George Way Upper, Marlboro, Md 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of himportant: If ite any injury or ot once. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 09/09/08 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 21. Signature of Funeral Service Lice Shead Mortagry Service, P.A. 1409 Fairlakes Pl Ste B Mitchellville, Md Approximate Interval Between Onset and Death 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final A515 weeks **Physician** disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner sseminated Fungal Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) The law requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No ate has been signed by the a page 2 should be detached 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ Yes 2 No 2 No 1 Tyes 1 Yes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA ၉ completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 29a. Certifier 1 [Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 4, 2008 RES-000 30. Name and address of person on who completed cause of death (Item 23a) (Type, Print) Melinda Morton 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) SEP 0 8 32. Registrar's Signature State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10a-f, perINF, G884, 10/7/08, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 8:10 pM Harold Hunter Callahan September 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens-Riderwood Nursing Home Silver Spring Prince George's If Under 1 Year | If Under 24 Hrs. | 8. B. Date of Birth (Month, Day, Year) April 14, 1917 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Months Min 1 X M 2 □ F Yrs Director 276-09-7142 91 Ohio Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits event, the Medical Experimen must be notified at Prince George Silver Spring Maryland Director 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Rd., Evergeen #2104 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆ Yes 2 ☐ No If Yes, Give Year or Dates: **WWII**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Exp. .it at any any. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No ģ Specify. 3 x Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military Intelligence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Percy F. Callahan ဥ Jessie Mable Hunter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Barkley - Niece 201 Braemar Creek, Williamsburg, Virginia 23188 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Crematory 09/09/2008 Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses Waller 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Coronary Artery Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗷 No 1 □ Yes 1 Tiyes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760.

death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

'natural", or items 23a or

DHMH 17 Rev 1/2001

+1

State

Registrar

Eugenio S. Machado, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

SEP 08

D24035

September 2, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

James Allen Carte	1	State of Maryland / Department of Health and Menta  I- For State Certificate of Death	al Hygiene	Reg. No. 200	8 3029					
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of D Month	Day Year	3. Time of Death					
Medical Examin		James Alan Carter, III	Septem	ber 14, 2008 4c. County of Death	1215 hrs					
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Pasadena  Pasadena	Death	Anne Arundel						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24Hrs. 8. Date of	Birth (MM/DD/YYYY) 9. Bir						
Director		217-17-6099 1 XM 2 F 34 Yrs. Months Days Hours	Min. Jan.	$6,1974  \text{N}^{\text{co}}$	untry) Carolina					
	t	Usual Residence of Decedent								
w any		10a. State 10b. County 10c. City, Town or Location Pasadena			10d. Inside City Limits  1 X Yes 2 No					
·land	ģ	TID TAMES TO A STATE OF THE STA		10g Citizen of What Cou						
ith the Maryland 23a or 28a-f show	Director	10e. Street and Number 581 Powhattan Road 21122	2	10g. Citizen of What Cou United S	tates					
h with	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original In Yes, specify Cuban, Mexican,		No- 14. Race - Amer White, etc.	ican Indian, Black,					
er dear	ᇍ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	Vhite					
urs aft tural"	흸	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give k		16b. Kind of Business	Industry					
72 hou	eee	Elementary/Secondary (0-12) College (1-4 or 5+)  Auto Body Mechanic		Collison	Repair					
5-0036 iled within 72 Hygiene. I other than the Medical	ompleted									
21215-0036 build be filed within 72 hours after death with the Maryland Mental Hygiene. marked other (han "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Be Co	James A. Carter, Jr. Deb	orah M.	lle, Maiden Surname) Harriman						
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	ဥ	19a. Informant's Name/Relationship (Type, Print)  James Carter, Jr./Father   19b. Mailing Address (Street and Number 19b. Mail	nber or Rural Route $d \cdot d \cdot Fed$	eralsburg,	MD 21632					
re, rand 1 and 1 and 1 Healt fitem er frau		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  1 X Burial 2 Cremation 3 Removal from State U. 1 1 1 1 Crematory or other place)	Date	20c. Location - City o						
Pages Pages nent of mnt: I		1 X Burial 2 Cremation 3 Removal from State Hill Crest Cem. 4 Donation 5 Other Specify:	09/18/0	9 Federal	sburg, MD					
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility  1. Signature of Funeral Service Licensee 22. Name and Address of Facility 216 N. Main St	Framptom	Funeral Home Lisburg, MD 2	1632 <sup>A</sup> .					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca failure. List only one cause on each line.			Approximate Interval Between Onset and					
/Medical Examiner		Immediate Cause (Final disease a. Cocaine and narcotic (methadone)	intoxica	ation	Death					
.xammer		or condition resulting in death)  Due to (or as a consequence of):								
	ē	Sequentially, list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated c.								
ted 1 1 1 1 1	Exa	events resulting in death) Last Due to (or as a consequence of):								
(0, e be executed ysician and burial - transit	edical	UNPENDED 23a,27,28a-f, perME, g884 10/15/08 TT								
30x 6876( leath certificate e attending physicare as the b	Σ	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	c pregnancy	23d. Date of delive Month	ry Day Year					
x 68 th certination trending the articles are	O	past 12 months?  4 Pregnant at time of death 5 Other (Specify)								
Box ne death of the atten	Physi	1 Yes 2 No 9 Unknown g Unknown	220 [	Did tobacco use contribute t	o the source of death?					
Division of Vital Records, P.O. Box 6876( the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy npletely filled in by the funeral director, page 2 should be detached for use as the b	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa			obably 4 Unknown					
of Vital Records, g Physician: The law require ther this certificate has been si neral director, page 2 should be	Completed				autopsy findings available ocompletion of cause of					
eco ne law te has	dmc			performed? death?						
tal Rec		25. Was case referred to medical 26.Place of Death								
Vita hysicia this ce	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	Nursing Home	Residence 6 Oth	er: Scene					
fing Ph	T:U	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work	_   ,	ribe how injury occurred						
Sion Attend r death. ector: by the i	atic	2 Accident Pending Fnd 9/14/08 Fnd 12:05 pm Tes 21			David Barrier City					
Division spital or Attendii ours after death. reral Director: A	Certification:	3 Suicide 6 X Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, et house	or To	ion (Street and Number or I wn, State) 681 Powl	nattan Rd					
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier		dena, MD	ated.					
To the Hos within 24 h To the Fur completely	Medical	one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc	ccurred at the time,	date and place, and due to	the cause(s)					
To wit	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	lonth, Day, Year)					
		The for M. King Tay and O.C.M.E.	OCME	September 15,	2008					
(x)		30. Name and address of person who completed cause of death (Item 23a)		1004						
$\overline{}$		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Ba	aitimbre, MD 2	1201						
St Regist	ate trar	: _								

State of Maryland / Department of Health and Mental Hygiene 30300 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** James M. Campbell, Jr. 7, 2008 21:15 PM /Medical September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County E1kton Cecil. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 XM 2 □ F Yrs. 144-26-6867 **Director** 75 March 26,1933 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits Maryland Ceci1 North East 1 ☐ Yes 2\No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 137 Riverside Drive 21901 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Vice President of Sales <u> Aircraft</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James M. Campbell Margaret McKenna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy B. Campbell / Spouse 137 Riverside Drive, North East, Maryland 21901 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State North East Methodist
Cemetery September 1 XX urial 2 □ Cremation 3 □ Removal from State 11, 2008 4 Donation 5 Other (Specify) North East, Maryland 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 Part1. Enter the disease, or complication, and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Betwoonset and De Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Each of John of Cause (Disease or injury that initiated events resulting in death) Last Examiner ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): s been signed by the attending physician should be detached for איז בא האוו Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) 2 ER/Outpatient 3 □ DOA Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient After this eral Director; After thi filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 20b. Signature 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

SEP 1 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month  $\frac{\overline{5}}{5},$ **Physician** Arthur Bernard Dreeben September 2008 9:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8100 Connecticut Avenue Chevy Chase Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Days 1⊠M 2□ F Months Yrs Director 088-12-7840 Feb. 15, 86 1922 New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ust be notified Director 1 X Yes 2 □ No MD Montgomery Chevy Chase 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō death with 23a 8100 Connecticut Avenue 20815 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1942— 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. event, the Medical Evanimer 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🖾 No Specify. 2 Specify: White 3 ₩ Widowed 4 Divorced natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Chemist RCA 27 is marked other ar traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental I Meyer Dreeben ပ Vera Heimann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other th Michael Dreeben - Son 3518 Bradley Lane Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 9/8/2008 Falls Church, Virginia 21. Signature of Funeral Service Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Coronary Artery Disease Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresqueries of): To the Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown ۾ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 □ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \boxed{\mathbb{K}} Residence 6 \subseteq Other (Specify) 1 TYes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No after death filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier **ledical** (Check only the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 6 108

State Registrar

Deidra Woods,

31. Date filed (Month, Day, Year) SEP 0 8

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

MD

D54241

4910 Massachusetts Avenue NW #304 Washington, DC 20016

			1 - State Registrar	oi Maryianu		tificate of D			g. No. 2	800	30302
E <sub>T</sub>	Physic		Decedent's Name (First, Middle, Last)     Clara Jean	Doubt				Date of Death     Month	Day	Year 2008	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and n			4b. City, Town, or L	ocation of Death	September	T	y of Death	F
4	E Adrilli	ı.c.	Wilson Health Care Center	,			nersburg			Montgo	mery
2.	Funeral Director		5. Social Security Number  508-26-4566  Usual Residence of Decedent	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, September		9. Birthp Coun	lace (State or Foreign try) braska
	/land ow at		10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	a-f sh	ctor	Maryland Montgomery			Gai	ithersburg				1 ☐ Yes 2 No
	vith the or 28 be not	Director	10e. Street and Number	-		10f. Zip Code		10	10g. Citizen of What Country?		
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21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by Funeral	Armed F	Forces? 2 🛣 No Give		Vas Decedent of Hisp f Yes, specify Cuben, □ Yes 2 2 No	Specify:	Rican, etc.)		ick, White, of	
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<b>d</b> 2	e filed wi al Hygier other th vent, the		17. Father's Name (First, Middle, Last)	)T				(First, Middle, M			System
<u>lan</u>	should be nd Mental marked c	To Be	Jens Paulsen					Anna Berg		r	
Maryland	0 8 8	-	19a. Informant's Name/Relationship (Type. Print)		19b. Maitin	g Address (Street an	d Number or Rura	al Route Number,	City or Town	, State, Zip	Code)
	s 1 and 2 of Health Item 27 i		Nancy Doubt - Niece/POA			Kingman Driv			ware 198	310	
Baltimore,	S to I		20a. Method of Disposition  1 ☐ Burial 2 【■ Cremation 3 ☐ Removal from	000	ce of Dispos metery, cren	sition (Name of natory or other place)		Date 2	0c. Location	- City or To	wn, State
Itim	permit. Pa Departmen Important: any Injury		4 □ Donation 5 □ Other (Specify)	Fort		In Crematory		7/2008	Brentwoo	od, Mar	yland
Bal	permit. Page Department of Important: If any Injury of once.		21. Signature of Funeral Service Licentee	Jour-	Hi    11	Name and Address nes-Rinaldi 800 New Hamp	Funeral Ho shire Ave	nue, Silve		g, Mary	1and 20904
	Physician /Medical Examiner		resulting in death)  a. Due to	caused the death. each line.	we		such as cardiac of acid		st,	10	Approximate Interval Between Onset and Death
68760, 0	tificate be executed g physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	o (or as a conseque							
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rds, P	The law requires that the ste has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to Reflect lesphage	death but not resulti	ing in the un	derlying cause given	in Part I. Terral		acco use con s 2 \( \sum No	tribute to th	e cause of death? ably 4 Junknown
Vital Records,	10 ==	Completed by	Presure wound	uno C	end	umene	mix	24a. Was an autopsy perform	ed2/	Were autor prior to con death? 1  Yes	psy findings available apletion of cause of 2 No
Ĭ.	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			Other		(Check only one			
ō	y Physer this eral di	1: To	27. Manuer of Death 28a. Date	of Injury 2	R/Outpatient 8b. Time of	3 DOA Other.  28c. Injury a Work?	4 Li Nursing Hor	ne 5 🗆 Resider 28d. Describe hov			)
<u>o</u>	Attending r death. ector: After by the fune	atior	1 ☑ Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	nth, Day Year)	Injury		s 2 □No		· many occur	100	
Division	tal or Atte s after dez al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined built	e of injury - At home ding, etc. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Numi State)	ber or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier (Check only one)  1	e best of my knowle basis of examinatio nner stated.	edge, death in and/or inv	occurred at the time estigation, in my opir	, date and place, anion, death occurr	and due to the ca ed at the time, da	use(s) and m te and place,	anner as sta	ated. the cause(s)
	Tot Tot	Ž	29b. Signature and title of certifier	. /	(	29c. License n			d. Date signe		
	66	'	> W. Rabert Bus		ten	V, 5041	115	S.	epten	elecr	4,2008
			30. Name and address of person who completed cau	48414	Ms.	Print) 201	RUSSETHERS	S.L. AVE BURGIN	1048	844	
	Sta Registr		SEP 0 8 2008	Registrar's Signatur	re	wes					

DHMH 17 Rev 1/2001

FIXT ME / May asis/me

			1 - State Of P	naryian		rtment of r tificate of	Death	Mental H	ygien Reg. N		3030:			
	Physic	an	1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath	ay Year	3. Time of Death			
	/Medi		Jack Harvey Denning					Augus	_	0 2008	4:35 P M			
	Examir	ner	4a. Facility Name (If not institution, give street and number	•		•	r Location of Deat	h	4	c. County of Death				
	Funeval	-	3701 International Drive 5. Social Security Number 6. Sex 7.	<b>,</b> #453 Age (In yrs. la	ast hirthday)	Silve If Under 1 Year	r Spring If Under 24 Hrs.	9 Date of B	irth	Montgome	ery place (State or Foreign			
	Funeral Director		210-14-7509 1 M 2 □ F Usual Residence of Decedent	83	V	Months Days	Hours Min.	(Month, E	1, Year	925 Penns	intn/)			
	yland now		10a. State 10b. County	10c. City	, Town or Loc	cation				T	10d. Inside City Limits			
	e Mar la-fst	ctor	Maryland Montgomery	ŀ		Silv	er Spring	g			1 ☐ Yes 2 📉 No			
	章 er 28	Dire	10e. Street and Number			10f. Zip Code			10g. C	Citizen of What Cou	ntry?			
	s 23a	eral	3701 International Drive				20906			U.S.	.A.			
36	s after de ", or item	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  1 ☒ Yes ≥ Uf Yes, Give	s? ] No	1	Vas Decedent of H Yes, specify Cuba □Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	specify Yes or N to Rican, etc.)	0-	14. Race - Ameri Black, White, Specify:	etc.			
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evanting court be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates  15. Decedent's Education	* WWII		ent's Usual Occup	ation		165		White			
215		Completed	(Specify only highest grade completed)	. 5.)	(Give F	kind of work done of NOT use retired	during most of wor d)	rking	100.1	Kind of Business/In	dustry			
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nd	and 2 should lealth and Mer m 27 Is marke her traumatic	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle	e, Maide	n Surname)				
Maryland		2	John Harvey Denning					essie Ta						
Ma			19a. Informant's Name/Relationship (Type. Print)							or Town, State, Zip				
as			Lillian R. Denning - Spot 20a. Method of Disposition					Date		pring, MI _ocation - City or To				
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 X Surial 2 Cremation 3 X Removal from Stat	e Arî	metery, crem ington	ition (Name of atory or other place Nationa	i 10//			•	,			
alti	mit. I partm porta / inju		21. Signature of Funeral Service Licensee		Ceme	terv	10/0	JO/ZUUO JEC-PIN/	ALT	ington, \	HOME, INC.			
<u></u>	e e e e		Trust n/pro		1	1800 New	Hampshir	ce Ave.	Sil	ver Sprin	nome, INC.			
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. line.	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between			
d.	Physician		Immediate Cause (Pal disease in condition a. Meso	theli	oma						Onset and Death			
	/Medical Examiner		resulting in death)  Due to (or a	s a conseque	ence of):									
		ē	Sequentially list conditions, if any, leading to immediate Due to (or a	s a conseque	ence of):									
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o a sonosque	01100 017.					- 3				
oʻ	e exec an an irial-tr		resulting in death) Last C. Due to (or a	ence of):										
68760,	icate be executed physician and s the burlat-transit	lical	d			···			_					
õ ×	sertific ding p	Mec	IF FEMALE:											
O. Box	the death certificate be executed y the attending physician and ched for use as the burlal-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	2 Fetal of at time of de	death 3 🗌	Ectopic pregnancy Other <i>(specify)</i>	′			23d. Date of delive Month	ery Day Ye <i>a</i> r			
ሚ ፓ	s that ned by deta	by Ph	Part II. Other significant conditions contributing to death	but not result	ting in the und	derlying cause give	en in Part I.	23e. Did 1	obacco	use contribute to the	ne cause of death?			
ecords,	require: been sig					-	<u>.                                    </u>	10	Yes 2	No 3 Prob	pably 4∭ Unknown			
Hec	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death, which is 4 hours after death, and the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached in the funeral director.	Completed						24a. Was auto perfo 1 □Yes	psy rmed?	prior to con death?	psy findings available mpletion of cause of			
VITAI	siclan certifi ector		25. Was case referred to medical examiner?  1   Ves 2   M No Hospital:   Hospi				26. Place of Deat							
5	Phys raldis	၉	1 ☐ Yes 2 ☒ No ☐ ☐ Inpat 27. Manner of Death 28a. Date of In		R/Outpatient 28b. Time of		4 Li Nursing Ho			6 ☐ Other (Specif	y)			
Sion	nding tth. :: Afte e fune	ţi	1 XNatural 5 Pending (Month, D	ay, Year)	Injury	28c. Injury Work	rai ? /es 2 □No	28d. Describe	now inju	ry occurred				
<u> </u>	Atter	iţi	3 □ Suicido 6 □ Could not be	jury - At hom	ne, farm, stree	et, factory, office		28f. Location (	Street ai	nd Number or Rura	l Route Number,			
5	rs after all or all or all or all or all or all Dir	Certification: To	# building, e	tc. (Specify)				City or To	wn, State	9)				
;	n 24 hou n 24 hou ne Funer	Medical	29a. Certifier (Check only one)  1 \infty Certifying Physician: To the bess 2 \infty Medical Examiner: On the basis and manner s	of examination	ledge, death on and/or inve	occurred at the tin estigation, in my op	ne, date and place pinion, death occur	, and due to the rred at the time,	cause(s date an	s) and manner as s d place, and due to	tated. the cause(s)			
i	To the withing the complete co	ž	29b. Signature and title of certifier			29c. License	number		29d. Da	ate signed (Month,	Day, Year)			
	10		1	r	~D		035635	5	Sept	ember 5,	2008			
			30. Name and address of person who completed cause of											
	Stat	0	Joseph Kaplan, M.D., 1181 31. Date filed (Month, Day, Year)  Regist	1 Pri	nce Ph	ilip Dr.	Suite 3	327, Olr	ıey,	MD 2083	2			
	Registra	_	SEP 0 8 2008	s digitatu	LORA	E								

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 11 2008 JAMICS /Medical 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) June 15 1937 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 **X**M 2 □ F 71 214-34-6561 Maryland Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Frederick Frederick Md. 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n 21703 5620 Avonshire Place, Apt. A United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 White Specify: ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4 or 5+) County Government Power Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Runion Charlotte V. Herbert Dove 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brother 3911 Sugarloaf Drive, Monrovia, Md. Larry Dove Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Derwood, Maryland 9/17/08 4 Donation 5 Other (Specify) St. Luke's Cemetery 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses M-00470 P. O. Box 5038, Laytonsville, Md. 20882 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day signed by the atter d be detached for in the past 12 months? 2 🗌 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2. No 1 Yes 26. Place of Death Check onl one 25. Was case referred to medical Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Nnpatient 2 No 2 ER/Outpatient 3 DOA 1 Tyes ၉ s after death.

I Director: After this ed in by the funeral di After this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury Certification: (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours after To the Funeral Direc completely filled in b To the Hospital 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shormaker

29b. Signature and title of certification

29c. License number PE5-000

600 North Wolfe St, Baltimore, MD, 21287

				partment of Health and Mertificate of Death		iene g. No. 20	08 30305
16	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month		3. Time of Death
	/Medi	cal	Jennifer R. L. Elwood		Septemb	er 3 2	008   09:40 P <sup>M</sup>
	Examir	ier	4a. Facility Name (If not institution, give street and number) 508 Kansala Drive	4b. City, Town, or Location of Death Annapolis		4c. County o	Arundel
L _	Funeral	-	5. Social Security Number 6. Sex 7. Age (In vrs. last birthda)	() If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
20	Director		150-68-9631 1□M 21 44 Yrs.	Months Days Hours Min.	(Month, Day, 12/27/1	Year)	New Jersey
	pur M		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Maryla f sho led at	JO.	Maryland Anne Arundel Annapoli				1 □ Yes 2 No
	r 28a- notifi	irect	10e. Street and Number	10f. Zip Code	10	ng. Citizen of Wi	nat Country?
	filed within 72 hours after death with the Maryland Hygiene. other than "natural"; or items 23a or 28a-f show ent, the Medical Examiner must be notifled at	Funeral Director	508 Kansala Drive	21401	U	nited S	tates
	r dear	nuer	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 Married 1 □ Yes 2 M No	. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
36	s afte	y Fi	1 □ Never Married 2 Married 1 □ Yes 2 M No 1 □ Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	White
8	2 hour atural	Completed by	15. Decedent's Education 16a. Dec	edent's Usual Occupation	11	6b. Kind of Bus	
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7	ed wit ygien yer tha	So		essor		Educati	
and E	be fill ad oth even	Be	17. Father's Name (First, Middle, Last)  James B. Lorenz	18. Mother's Name		laiden Surname	)
Maryland 21215-0036	hould d Mer marke matic	ဠ		Edith Cal		City on Town C	1-1- 7:- O-1-1
$\overline{\mathbf{z}}$	ulth an 27 is i			Kansala Drive, Anna			
ē,	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Disp		<del></del>		ity or Town, State
Ē	Pages nent of P ant: If ite		I Bundi 2 Li Cremation 3 Memoval from State	i i	5/2008 E	dgewate	r, Maryland
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signatur of Fyr al, Septice Licensee	22. Name and Address of Facility Ge	orge P. 1	Kalas Fu	uenral Home
	<u>6 2 5 0</u>		2	973 Solomons Island	d Rd., Ed;	gewater	, MD 21037
			23a. Part . Enter the disease, or complications that caused the death. Do not es shock, or heart failure. List only one cause on each line.		or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  A Preast	concer			4 yeurs
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		ner	Sequentially list conditions, if any, leading to immediate couls. Enter Underlying Due to (or as a consequence of):				
	ecutec ind transi	Examiner	Cause (Disease or injury that initiated events c.				
8760,	cate be executed physician and the burial-transit	E	Due to (or as a consequence of):				
287	certificate be executed ding physician and ise as the burial-transit	dical	d				
Box	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date	of delivery
	0 0	Physician/Me	in the past 12 months?  1 Ves 2 M/No 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Mont	
J O	at the by th	hys	9 ☐ Unknown 9 ☐ Unknown				
	The law requires that the date has been signed by the bage 2 should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		\ /	oute to the cause of death?
Vital Records,	requi	Completed			1 Yes	s 2 No 3	Probably 4 Unknown
ě	e la has je 2	mpl			24a. Was an autopsy perform		ere autopsy findings available or to completion of cause of ath?
<u>a</u>		e Co	25. Was case referred to medical		1∐ Yes 2	No 1L	Yes 2 No
	Physician: r this certific ral director,	O B	examiner?  1   Yes   2   No	26. Place of Death	ne 5 <b>X</b> Resider		(Engelta)
0	ding Physician: h. : After this certifics funeral director, p	i.i	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Pescribe hov		
<u> </u>	or	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	•		
UIVISION	or Atten after deatl Director; in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,		or Rural Route Number,
_	ppital Durs a neral I	=1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the oo	uoo(o) and mon	
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	edical	(Check only one) Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, da	ite and place, ar	ner as stated. Id due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed	(Month, Day, Year)
			Jellunten mo	D22230	5	20 tem	ber 4,2008
	100		(Check only one)   Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier   WO   30. Name and address of person who completed cause of death (Item 23a) (Type   Team & WO   90.  31. Date filed (Month, Day, Year)   37. Registrar's Signature   SEP 0 5 2008   38.	, Print)	-1 11-2	~ 4	
1 -	- CA	10	31. Date filed (Month, Day, Year) 3 Renistrar's Signature	opergate Re	-3	An	replis MO Zirol
	Sta Registr	ar	SEP 0 5 2008 Som &	ale			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Demetrio Paul Errigo /Medical 2008 4:04 p September 4. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days XXM 2□ F Hours Director 579-42-7045 76 Feb. 11, 1932 Washington, DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar coust by multiple at Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Olney the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4601 Morningwood Drive Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after comportant; if item 27 is marked and injury or any inj Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Giovanni Errigo Anna Scopelliti ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Giovanna Errigo/Wife 4601 Morningwood Drive, Olney, MD 20832
of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 10 2008 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Myocardial days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-t Due to (or as a consequence of) Box 68760. attending physician for use as the buria certificate be Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Ye ar Pregnant at time of death signed by the a 0 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? hasl 24a. Was an autopsy performed? Yes 2. No this certificate of Vital 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes ٩ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending After Division 1. Natural 5 Pending investigation s after death.

I Director: A
id in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital c within 24 hours af To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Physicics 10055694 12+1

State Registrar ALOK M
31. Date filed (Month, Day, Year)
SEP 0-8

32 Registrar's Signature

4000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHUR

Oney-Laytonsville Rd.,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of	Maryland					/lental H	ygien	е			
			Registrar			Cer	tificate c	t Deat	h	D D-1 - 1	Reg. N	0.20	08	303	07
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	the N 28a-f	Director	OK OKLAHO  10e. Street and Number	MA CITY			CHOCTA 10f. Zip Cod				10a C	itizon of W	hat Count	**	
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36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied Armed Forc 1 1 Yes 2 If Yes, Give Year or Date	<sup>□ No</sup> 1996-	- 1	Yes, specify C ☐ Yes 2[X]			Hican, etc.)		Black Specify:			
5-0036	be filed within 72 hours after death with the Marylan ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	15. Deceden	t's Education	2000	16a. Deced	ent's Usual Oc	cupation			16b.	ay 2008  A Time of Death  MONTGOMERY  9. Birthplace (State or Foreign Country) OKLAHOMA  10d. Inside City Limits 1  Yes 2  No  Notice of What Country?  U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: WHITE  Kind of Business/Industry  DEFENSE In Surname)  McLAUGHLIN  or Town, State, Zip Code)  73020  Occation - City or Town, State  MIDWEST CITY, OK  ATORIUM, P.A. LE, MD. 20737  Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  Use contribute to the cause of death?  Approximate Interval Between Onset and Death  24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No  1  No 3  Probably 4  Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1  No 3  Probably 4  No No No No No No No No No No No No No			
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21	filed within Hygiene. Ither than "	ပ်	12				U.S. 1								
and	ould be fii Mental H larked otl	Be	17. Father's Name (First, Middle,	,				18. Mo			le, Maide		,		
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	nd 2 lith a 27 is r tra		EVERETT M. EDI	,										C00e)	
re,	(i) (i) 1		20a. Method of Disposition		20b. Plac	ce of Dispos	sition (Name of natory or other)	LASI .		Date				wn, State	
E O			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 <b>∑</b> Removal from St <i>pecify)</i>	ate	-			ENS 9.	-13-200	) 18 N	TDWE!	ST CI	דידע טג	
Baltimore,	permit, Page Department Important: If any Injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM.P.A.											.A.	
	St.		MOUU91   5801 CLEVELAND AVE., RIVERDALE, MD.												
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition			O m o	TTT T 172	era i ca c c						Interval Betwee Onset and Dea	n ith
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	Examiner	,	Sequentially list conditions	b											
	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequer	nce of):									
В	xecute and Il-tran	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C													
8760,	ficate be executed physician and s the burial-transit														
Q)	ificate g phy as the	edical		d											
Вох	death certifi e attending d for use as	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregnanc n 2 □ Fetal de		Ectopic pregna					23d. Date	of deliver	ry	
O. E	that the death certifi ed by the attending detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		t at time of deat		Other (specify,					Mont	th I	Day Yea	r
Δ.	that the	Phy	Part II. Other significant condition	ens contributing to deat	h hut not resultir	ng in the un	derlying cause	given in Par	+ 1	23e Dio	tobacco	use contrib	auto to the	a cause of deat	h2
ds,	sign sign d be	d by	•			.g	donying cadoo	giveiriiri							
Ö	w requ	Completed								24a. Wa		1	oro auton	ou findings avai	ilable
Re	The lav	dwc								aut per	opsy formed?	pri	ior to com ath?	pletion of cause	e of
ita		a	25. Was case referred to medical					26. Pla	ce of Deatl	1□ Yes Check only	2 X N	0 1	_Yes 2	2 □ No	
<u>'</u>	is dir	To B	examiner? 1 □ Yes 2 汉 No	Hospital: 1 📉 Inp	atient 2□ER	l/Outpatient	3□ DOA	Othor:				6 □Other	(Specify	)	
0 4	Ing Pl	:uo	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month,	njury 28 Day Year)	Bb. Time of Injury	28c. Ir	jury at /ork?		28d. Describe					
<u>Si</u> 0	Attending r death. ector: After by the fune	cati	2 Accident investig 3 Suicide 6 Could n	ation		0.7	M 1	☐Yes 2[	□No						
E	after death after death Director: d in by the	Certification:	4 ☐ Homicide determi	ned 28e. Place of	injury - At home etc. (Specify)	e, farm, stre	et, factory, offic	ce		28f. Location City or T	(Street a own, Stat	nd Numbei e)	or Rural	Route Number,	
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the be	est of my knowle	edge, death	occurred at the	time, date	and place,	and due to th	e cause(s	and man	ner as sta	ited.	
	To the H within 24 To the F complete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and ple and manner stated.												
			29b. Signature and title of certifier					nse numbe			29d. Da			Jay, Year)	
	1+1	}	30 Namo and address of page	who completed cause of		) (T: :- =		1238 <b>7</b> 4			4 1 M			мтғр	
			30. Name and address of person values IOUIS J. MOYE		USN	oa) (Type, P	rint)			DA MD				AL ند به ۱۰	
	Sta	te	31. Date filed (Month, Day, Year)	324Reg	strar's Signature	e									
	Registr	ar	<b>SEP 0 8</b>	2008	us B.	( Salar									

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Gerald Robert Eckebrecht September 5, 2008 8:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 334-32-6856 67 Director Nov. 8, 1940 Illinois Usual Residence of Decedent Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits show ms 23a or 28a-f si grast be notified 1 ☐ Yes 2 👿 No Director Maryland Montgomery Wheaton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2810 Dawson Street Funeral 20902 USA th and Mental Hygiene.
7 Is marked other than "natural", or items: traumatic event, the Medical Examination 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White 1958-64 Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Eckebrecht Caroline Reese ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michell D. Hartzman/Daughter 19300 Liberty Heights Lane, Germantown, MD 20874 of Health permit. Pages 1 and 2 Department of Health Important: If Item 27 any Injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sept. 10 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licenses 22 Name and Address of Eachity Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Atrial Fibrillation /Medical Due to (or as e consequence of) Examiner Acute Myocardial Infarction Sequentially list conditions. Examiner Due to (or se a consequence or, cause. Enter Underlying Cause (Disease or injury that initiated events be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of). physician a Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Leg Ischemia and Gangrene 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy certificate 2 X No 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Attending. 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide Š Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or filled in 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60826 September 5, 2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 1500 Forest Glen road, Silver Spring, MD 20910 Kshama Garg, 31. Date filed (Month, Day, Year) 320 Régistrar's Signature State SEP 0 8 Registrar 2008

08-06828		Please Type or Print in Black Indelible Ink. Ensu	
Juan Pablo Mos		otate of Maryland / Dopartmont of Floatti a	nd Mental Hygiene 2008 303
Physicia	and/	1- For State Registrar 9-9-084men0#8. PerFHPGC: Certificate of Death  1. Decedent's Name (First, Middle, Last)	Reg. No.  2. Date of Death  3. Time of Death
Medical Exami			Month Day Year September 6, 2008 0615 hrs
6			or Location of Death 4c. County of Death
`		N/B Rt 95 and E/B Rt 216 Laurel	Howard
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Your Months De	ays Hours Min. 1983 Country)
Bilector		NONE 1XXM 2 F 25 Yrs. Usual Residence of Decedent	ays Hours Min. 1-19-2008 Guatemala
any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
and show nce.	'n	MD Howard Laure1	1 Yes 2 X No
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code	
th the 33a or		9304 Cabot CT 20723	
ath wit tems 2	Funeral		Hispanic Origin? (Specify Yes or No- pan, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
ter des		X 1 Yes 2 X No	No specifyCustomals Specify: IThis
ours af atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup	pation (Give kind of work done 16b. Kind of Business/Industry
6 172 hc an "ng cal Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	ife. DO NOT use retired)
5-0036 fled within 7. Hygiene. 1 other than	щ	6 Laborer	Constuction
15- e filed al Hyg ed off	Be C	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)
Baltimore, MD 21215-0036  germit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Haulth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Luis Alfredo Moscoso  19a. Informant's Name/Relationship (Type, Print )  19b. Majiing Address (Str	Maria Estela Flores reet and Number of Rural Route Number, City or Town, State, Zip Code) Ct Laurel Md 20723
MD id 2 shoulth and m 27 is aumati		Edwin Moscoso(Cousin) 9304 Cabot	Ct Laurel Md 20725
re, s l and f Heal If item er tra		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of a crematory or other place)	cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of He Important: If ite			9-15-2008 Guatemala ess of Facility Mason Funeral Service
Salt ermit. Peparti mport			
	_	23a. Part Venter tive disease, or complications that caused the death. Do not enter the mode of dying	eland Ave Riverdale Md 20737
Physician /Medical		failure. List only one cause on each line.	Between Onset and Death
xaminer		Imme. late Cau e (Final disease or condition resulting in death)  Due to (or as a consequence of):	
		Sequentially list conditions, b	
	Examiner	if any, leading to immediate Due to (or as a consequence of):  Cliesces Enter th derlying Cause Cliesces a latin the little of C.	
d Sit	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Atlending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the bunal.	an/Medi	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1	23d. Date of delivery  3 Ectopic pregnancy Month Day Year
ox 6 ath cer attendi	:5 i	4 Pregnant at time of death 5 Other (Specify)	
the de ched f	Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying caus	se given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O.	þ	, , ,	1 Yes 2 ✔ No 3 Probably 4 Unknown
rds, require	Completed		24a. Was an 24b. Were autopsy findings available
cor e law i e has b	gm		autopsy prior to completion of cause of death?
I Re n: Th rtificat or, pag	ပ္ပ	25. Was case referred to medical 26.Pla	1 ✓ Yes 2 No 1 ✓ Yes 2 No ace of Death (Check only one)
Vita ysicia his cer direct	8	examiner? 1 ✓ Yes 2 No	Other: A Nursing Home 5 Residence 6 Other: Scene
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should it.	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. In	njury at Work?  28d. Describe how injury occurred  Driver sport utility vehicle fixed object collision
ivision or Attendi after death. Director:	ertification:	1 Natural 5 Pending Sep 6, 2008 0611 hrs 1 2 ✓ Accident Investigation	Yes 2 No
IVIS I or A after a	흷	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	or Town, State)
DIV To the Hospital or within 24 hours afte To the Funeral Dir	O	4 Homicide determined (Specify) Interstate/Express  29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time.	N/B Rt. 95 and E/B Rt. 216, Laurel, MD
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opini	, date and place, and due to the cause(s) and manner as stated.  ion, death occurred at the time, date and place, and due to the cause(s)
To To	Mec	and manner stated.	ense number 29d. Date signed (Month, Day,Year)
		My Ann Mo	C.M.E. September 6, 2008
7		30. Name and address of person who completed cause of death (Item 23a)	
IN O		<u> </u>	et, Baltimore, MD 21201
			OCME
Regist	ıaı	SELIA A FOAD TO THE	

DHMH 17 Rev 1/2001 OCME 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 8, 2008 9:53 P M Sheila Ruth Jablow Frater Sept. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Arundel Anne Arundel Medical Center Annapolis Anne 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex 1 M 2 F 68 194d Delaware 222-22-9031 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Anne Arundel Severna Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21146 U.S.A. 4 Giddings Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) X-Ray Technician Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Jablow Rose Brodsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Giddings Ave., Severna Park, MD 21146 Arthur Frater Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 9/11/08 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Wilmington, DE Tewish Community

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic executions. Physician /Medical

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

Be

MD

**Funeral** 

**Director** 

Examiner

attending physician and for use as the burial-trar I Director: A d in by the f

Be

Certification: To

Medical

25. Was case referred to medical examiner?

29b. Signature and tite of certifie

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

After t

within 24 hours a

To the Funeral C

Division or Vital Records, P.O. Box 68760,

	4 □ Donation 5 □ Other (Specify)	Dewish	Community	C,CIII.			·
	21. Signature of Funeral Service Licensee		Schoenber 519 Phila	of Facility g Memori delphia	ial Chape Pike, Wi	l lming	19809 ton, DE
dical Examiner	23a. Part1. Enter the disea of shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due			Approximate Interval Between Onset and Death			
Completed by Physician/Medical	in the past 12 months?	outcome pf pregnancy ve birth 2 ☐ Fetal death regnant at time of death nknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1044	2	3d. Date of deli Month	very Day Year
ed by Ph	Part II. Other significant conditions contributing to Small bowel of			in Part I.	23e. Did tobacco us		the cause of death? obably 4 ∐Unknow
Complete	end Stage renal	disease	?		24a. Was an autopsy performed? 1☐ Yes 2☐ No	prior to death?	topsy findings available ompletion of cause of 2 □ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State Registrar

12

DHMH 17 Rev 1/2001

Stephen ()lexo 31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 ☐ Could not be

1 Inpatient 28a. Date of Injury (Month, Day Year)

and manner stated

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D58510

1 ☐ Yes 2 ☐ No

28b Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of	iviai yiai		rtificate of			_	Reg. No.	6111	8	3031	
	Physici	an	Decedent's Name (First, Midd			<u>-</u>				2. Date of De Month	Day	/ Ye		3. Time of Death	
	/Medi	Frederick Joh		Sept.  4b. City. Town, or Location of Death					2, 2008 3:1						
	Examir	4a. Facility Name (If not institution  Anne Arundel						4c. County of Death  Anne Arundel							
-	Funeral		5. Social Security Number		'. Age (In yrs.	last birthday)	If Under 1 Year		er 24 Hrs.	8. Date of Bir	th ,			idel ce (State or Foreign r)	1
,	Director		001–28–7400 Usual Residence of Decedent	1 <b>⊠</b> M 2□ F	70	Yrs.	Months Days	Hours		(Month, Da May 26			Country	NH	
	/land ow at		10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation						10d	. Inside City Limits	-
	e Mar 3a-f sh tiffed	ctor	MD Anne	Arundel			Aı	mold	l					1 ☐ Yes 2 No	
	vith th	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What	Country	1?	
	eath v is 23a must	eral	1001 Landon La	ne 12. Was Deced	lont Svor in II	6 12		1012	Printed (Coope	if you or No		USA 14. Race - A		Indian	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifled at once.	þ	1 □ Never Married 2 Mar 3 □ Widowed 4 □ Divorced	Armed Ford	es?		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2☑ No			lican, etc.)		Black, V Specify: V	hite, etc		
50	72 hc natur	eted	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during me	ost of working	a		nd of Busine			
12	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	1	notive Pa					ampion 19 Com	-		
9	filed hygie	ပိ	17. Father's Name (First, Middle	Last)		Auco	IOCIVE P	T		(First, Middle,			parry		_
lan	Juld be Jental rked c	To Be	Frederick E.	Gage				Ma	rgaret	. McGar	rigl	.e			
ary	2 sholl and Mis ma	_	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Num	ber or Rural	Route Numb	er, City o	r Town, Stat	e, Zip C	ode)	_
<u>გ</u>	and lealth m 27 her tr		Jacqueline M.	Gage/Wife	los, s		Landon I								
Baltimore,	Pages 1 tment of F tant: If ite		20a. Method of Disposition  1 ☐ Burial 2 X Cremation  4 ☐ Donation 5 ☐ Other (3	Specify)		lantic	sition (Name of matory or other pla Cremato	ry		8,	Gle	cation - City en_Bur	nie	, MD	
Ba	Depar Impor any In		21. Similare Funeral Service	EA/Cer		Ba	arranco 8 95 Gov. F	Son Son Sitch	s, P.A ie Hwy	. Seve	erna erna	Park .	Fune MD	ral Home 21146	
	Physician / Medical Examiner sthe purial-transit	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	r as a consequence as a	uence of):	er the mode of dyi	ng, such a	as cardiac or	respiratory au	rrest,		ly Ly	pproximate iterval Between inset and Death	
68760,	rtificate be ng physicia as the bur	Aedical	IF FEMALE:	d											
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		th 2□Feta nt at time of d	Ideath 3□	Ectopic pregnanc Other (specify)	у			2	23d. Date of Month	delivery Da	ay Year	
Records, P	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditi	ons contributing to dea	th but not resu	ulting in the ur	nderlying cause giv	en in Part	t i.	23e. Did to				cause of death? ly 4	
al Reco	sician: The law r certificate has be rector, page 2 sh	Completed										death	autopsy to comp 1? (es 2)	y findings available letion of cause of ☐ No	
Vita	Physician: r this certifica ral director, p	o Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 No	Hospital: 1 🛣 Ing	noticet OF	ED/Outratia	t 3CT DOA Oth	or.		Check only o			<del></del>		_
0	g Phys er this eral dir	$\vdash$	27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of	28c. Inju	rvat		e 5 🗌 Resid			Specify)		
Š	ending lath.	atio	1 Natural 5 Pendir investi	gation	Day Year)	Injury	M 1 □	rk? ∣Yes 2.[	No						
DIVISION	of or Attend after death. I Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	sined   28e. Place 0	f injury - At ho j, etc. <i>(Sp</i> ec <i>if</i> )	ome, farm, stre	eet, factory, office		28	If. Location (S City or Tox	Street and vn, State,	d Number or	Rural F	loute Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  1 Certifyii 2 Medical	ng Physician: To the b Examiner: On the bas and manne	is of examina	wledge, death tion and/or in	n occurred at the ti vestigation, in my	me, date a opinion, de	and place, areath occurred	nd due to the d at the time,	cause(s) date and	and manne	r as state due to th	ed. ne cause(s)	_
	To the within 2 To the complete	Me	29b. Signature and title of certifie				29c. Licens	se number			29d. Date	e signed (M	onth, Da	y, Year)	_
)			b h	rend Bech	, MO		D41	052	7		0	9/02	108		
Cd	4 1041		30. Name and address of person	who completed cause	of death (Item	23a) (Type, I		Suxu	4 Anr	raphis	. ME	7.100	100		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 5		gistrar's Signa	ture	- Mary 1	_	1	port	4				

		Fied	State of Ma								-egible.		
		1 - For State Registrar	State of Ma	arylariu /		tificate of			eritai riy	/	2009	3031	2
ŵ		Hegistrar  1. Decedent's Name (First, Middle)	, Last)			inoate or	Death		2. Date of De		2000	3. Time of Death	_
Physic		Warren	William	ш	oove	r			Month	Day 4	2008	12:30 p <sup>M</sup>	ı
/Med Exami		4a. Facility Name (If not institution			SOVE	4b. City, Town, o	r Location		Sept.	4c. (	County of Dea		
		1711 Portland A	venue			Fort Wa				Pr	ince G	eorges	
Funeral		5. Social Security Number	177 M 20 F	e (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	9. Bir	thplace (State or Foreign ountry)	n
Director		515-24-9148 Usual Residence of Decedent	8	35	115.		1		Feb. 1	5,192	3   ]	<u> Lowa</u>	
/land		10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits	
a-fsh	ţċ	Maryland Prince	Georges	Fort V	Wash	ington						1x Yes 2□No	)
or 28	Oire	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What C	ountry?	
ath w	Funeral Director	1711 Portland A				20744					ed Stat		
er de items	nue	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of H f Yes, specify Cub	lispanic Oi an, Mexica	rigin? (Spec an, Puerto P	cify Yes or No Rican, etc.)	D- 1	<ol> <li>Race - Ame Black, Whi</li> </ol>	te, etc.	
oours aft	by	1 ☐ Never Married A ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	10		I⊡Yes 2 <b>X</b> No	Specify	<i>'</i> :			Specify: Wr	nite	
2 hou zatura	ted	15. Decedent		16	a. Deced	lent's Usual Occup	ation	-4 -6		16b. Kin	nd of Business	/Industry	ī
thin 7 e. an "n Med	Pe e	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. I	kind of work done OO NOT use retired	d) auring mo	si of workin	g				
ed wi	Completed		5 <del>t</del>		<u>Mini</u>	ster					igion_		
be fill he fil	Be	17. Father's Name (First, Middle, John Colburn H	*						(First, Middle	, Maiden S	Surname)		
In yild II Z IZ-DUDO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ြို	19a. Informant's Name/Relationsl	·	19	9h Mailir	g Address (Street		sie Mci		ner City or	Town State	Zin Code)	_
nd 2 sulth ar		Ruth L. Hoover				Portland							
parinii Die, Mai yilailu Aila 19-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of	cei.	Septe	ate mber	20c. Loc	cation - City or	Town, State	_
Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 4 X Donation 5 ☐ Other (S)		Medi	asn: cal	agnivers. Center	ity	4, 20		Wash	nington	D.C.	
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service	Licensee /	1	22	. Name and Addre	ss of Facil	lity Col	umbia 1	Mortu	ary Se	rvices, P.A	7.
7 205 2		1 Jun	. O con	2							20706		_
		23a. Pall . Enter the disease, or shock, or heart fallure. List	complications that caused only one cause on each lir	the death. Done.	o not ent	er the mode of dyir	ng, such a	s cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				uncompl	icate	ed					
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or Attending Physician: The law requires that the death certificate be executed ther death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the buriat-transit.	dical		d										
certific ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy		-	7.				Od Data at da	li com	
atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other <i>(specify)</i>	у			-	3d. Date of de Month	Day Year	
t the c	hysi	9 Unknown	9□Unknown										
s tha	by P	Part II. Other significant condition	ns contributing to death bu	ut not resulting	in the u	nderlying cause giv	en in Part	l.	23e. Did	tobacco us	se contribute t	to the cause of death?	
equire en sig									1 🗆	Yes 🏋	]No 3□P	robably 4 Unknowr	1
law r las be	Completed								24a. Was	psy	24b. Were a	utopsy findings available completion of cause of	a
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Phys or this	- To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur	ry 28b	Outpatien  Time of	1 3 DOA	4 🗆 N		ne 5 Res 8d. Describe		Other (Spe	ecify)	_
nding th. :: Afte	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	g <i>(Month, Day</i> jation	Y Year)	Injury	28c. Injur Wor M 1 🗆	rk? ∣Yes 2⊑			,,			
Afte or dear dear dear dear dear dear dear dea	Certification:	3 Suicide 6 Could r 4 Homicide determ		ury - At home, t	farm, str	eet, factory, office		2		Street and wn, State)		lural Route Number,	
ital or rs after rai Dia	Cert		, and the same of	(0,000)					-	wit, blate)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier X Certifyin (Check only 2 Medical one)	g Physician: To the best of Examiner: On the basis of and manner sta	examination a	ge, death and/or in	n occurred at the ti vestigation, in my o	me, date a opinion, de	and place, a eath occurre	nd due to the ed at the time	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)	
o the	Mec	29b. Signature and title of certifier		ileu.		29c. Licens	se number			29d. Date	e signed (Mon	th, Day, Year)	-
FSFO		Des la	12.00			12/0	(0 (0 (			Su	1 9:	2008	
)		30 Name and address of person	who completed cause of de	eath (Item 23a	) (Type,		W CA C	9 3		any)	7, 1,00	0	
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			For State Registrar	State of Ma	aryland		partment of F ertificate of I		-	_	200	10	20215
			Registrar     Decedent's Name (First, Middle, I	_ast)			erincate or i	Dealli	2. Date of De		then C C	10	3. Time of Death
•	hysicia		•	dja Hobens					Septen	nber	3 200	ear 8	7:00 PM
	/Medic xamin		4a. Facility Name (If not institution, g				4b. City, Town, or	r Location of D	Death	40	c. County of [	Death	
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	neral ector		112 26 6990	1 DM OFTE	e (In yrs. la 92	ast birthda Yrs	Months Days		Min. 8. Date of Bir (Month, Date of Feb 17)	th ay, Year <b>7 ,</b> 1	916 N	Counti Counti CW	ace (State or Foreign ry) Jersey
land	ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or	r Location					10	d. Inside City Limits
d Z1Z15-UU36 filed within 72 hours after death with the Maryland Hygiene.	d other than "natural", or tems 23a or 28a+ show event, the Medical Examiner must be notified at	ctor	MD Howar	rd	El	lico	tt City						1 ☐ Yes 2 🛣 No
ig the	or 28 3e no	Dire	10e. Street and Number	_			10f. Zip Code			-	itizen of Wha		•
eath v	nust	eral	3004 N. Ridge F	12. Was Decedent	Ever in 11	S 1	21043	lispanic Origin	2 (Specify Yes or No		nited  14. Race - A		
fter de	r Item	Funeral Director	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 🔀			<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>		uerto Rican, etc.)		Black, V		
USC ours at	ral"; or Exam	þ	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☑ No	Specify:			Specify:	Wh	ite
215-0036 thin 72 hours af e.	dical	eted	15. Decedent's (Specify only highest of	Education grade completed)		16a. De	ecedent's Usual Occup iive kind of work done of ie. DO NOT use retired	ation during most of	f working	16b.	Kind of Busin	ess/Indi	ustry
within ene.	than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		Registered			Н	ealthc	are	
e filed	other ent, tl	BeCc	17. Father's Name (First, Middle, La				TREGISCEI CO		Name (First, Middle				
Ian Jid be Aental	rked tic ev	To B	Vasil Chumak					Sophia	a unkr	nown	l		
Maryland d 2 should be file th and Mental Hy	item 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type. Print)			ailing Address (Street						Code)
C = (		-	Neil D. Doran/N	iephew	OOK D		0 Vollmerh						
Baltimore, bermit. Pages 1 ar Department of Hea	or ot		20a. Method of Disposition 1 ☐ Burial 2   ☐ Cremation 3			_	sposition (Name of crematory or other place	1 -	Date -4-2008		Location - City		vn, State
baltimor permit. Pages ' Department of H	ortant injury	-	4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lic				Crematory 22. Name and Addre				nover,		ly FH Inc.
Dep Te	any ir		Done Colla	- William	M010		4112 Old C	olumbia	narry n. v a Pike Ell	lico	ke s r tt Cit	v. l	MD 21043
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Phys	ician		Immediate Cause (Final disease or condition	,	C	VI	9						Onset and Death
	dical niner		resulting in death)	Due to (or as	a consequ	ience of):	- \ /						
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uted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	,							
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<b>BOX</b>	for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal	death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/			23d. Date o Month		ry Day Year
j te j	y the	ysi	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9☐Unknown									
requires that the	ned b	by Pi	Part II. Other significant conditions	s contributing to death b	ut not resu	ilting in th	e underlying cause giv	en in Part I.	23e. Did	tobacco	use contribu	te to the	e cause of death?
ecords,	en sig	ed b							_ 10	Yes	2□ No 3[	] Proba	ably 4 Unknown
all b and C	(A) a.i	Completed							24a. Was	psy	prio	r to com	osy findings available appletion of cause of
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Or VITAL Physician: T	certiff rector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:		ED/0	ationt 317 DOA Oth	or.	Death (Check only				
	After this certific funeral director,	.T	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 ☐ Inpatie	iry	ER/Outpa 28b. Tim	ie of 28c. Injur	4 LI Nursi	ng Home 5 Resi			Specify	)
VISION Attending r death.	r: Aff	atio	1 X Natural 5 Pending 2 Accident investigat		y rear)	Inju		k? Yes 2∐No					
I or Attending after death.	recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of inj building, et	ury - At ho	me, farm,	, street, factory, office	_	28f. Location ( City or To	Street a	and Number o	or Rural	Route Number,
pital o	illed ir		One Cardillar 157 Cardificines	Dhusiaian Ta the heat	of mu know	ulodao d	a of has a surveyed at the time				(a)		
To the Hospital or Attendi within 24 hours after death.	e Fun	Medical	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	f examinat	tion and/o	or investigation, in my	ppinion, death	occurred at the time	, date a	nd place, and	er as sta due to	the cause(s)
Vithin	сопр	Me	29b. Signature and title of certifier				29c. Licens			29d. D	ate signed (A	∕lonth, [	Day, Year)
			Hom	an			0.35	5309		S	eptemb	ær	4, 2008
(3) 2	~	ļ	30. Name and address of person wh	o completed cause of c	leath (Item	23a) (Ty	pe, Print)	11.100	C(1)-1		-	√\	21010
	Cto	to	31. Date filed (Month, Day, Year)	32. R	ar's Signa	J KJ( ture		まうか	. Ellicot	10	119,1	III	12145
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0452 PM MC QUEEN DRUCILLA 2008 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🛛 F 86 134-18-5875 May 22,1922 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 XTYes 2 TINo Director MDSt. Mary's Great Mills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20634 45515 Brawney Street Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 □Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be <u> Bennie McQueen</u> <u>Fannie Williams</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai once. Louise Turner/Daughter 45515 Brawney St.,Great Mills, MD 20634 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Maryland Veterans |9/11/2008|Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Juneral Service License 6500 Allentown RD., Camp Springs, MD 20748 23a. Part \ Enter the disease, or correlations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC ARRHITHMA MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner KESFIR ATORT HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dise to (or as a consequence of) COMLESTIVE HERRIT Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1, Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: / 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

Box 68760, o. Records, Vital ð Division

law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

Hospital or Attending Physician:

State Registrar

completely

within 2.

31. Date filed (Month, Day, Year)

P ESTERNAS

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DO062662

CONKROTOWN

29d. Date signed (Month, Day, Year)

20650

09/02/2008

MD

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nathaniel Joseph, August 30, 5:30 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 2315 Brooks Dr., #201 Suitland Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1₩ 2□F 239-90-7602 56 Director March 25, 1952 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Example 1, and be notified at P.G. Suitland ty Yes 2 No MD Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S. 20746 2315 Brooks Drive #201 by Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after 1 ☐ Never Married 2 ☑ Married African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nathaniel Joseph Amanda Hill 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Joseph-Spouse 2315 Brooks Dr., #201, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Surial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) ò permit. Page Department Importent: If any injury or Cedar Hill Cemetery 9-8-08 Suitland, Maryland 21. Signature of Funeral Service tricensee 22. Name and Address of Facility 2504\_28th St., N.E. Bonnette & Assoc. Funeral Home Inc. WDC 20018 shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 Physiclan/Medlcai as the use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the all ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 🗌 Yes 3 Probably 4 Unknown 2**V**No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home SX Residence 6 Other (Specify) No ٩ 1 Tyes 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 2 Accident 5 Pending investigation death. Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l or A 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number H0059884 30. Name and address of ted caus f death (Item 23a) (Type, Print) way TINISHA JORDAN 31. Date filed (Month, Day, Year) State 2008 Registrar 0 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 7:55 pM Irene Landreth August 25, 2008 Myrtle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 502 Burnt Mills Avenue Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Aug. 14, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Min. Year! Months Hours 1 M 2 X F 242-24-4819 85 Director 1923 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examina must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 Burnt Mills Avenue 20901 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. ğ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) yes 1 and 2 should be filed within 7 to Health and Mental Hygiene. If item 27 is marked other than "n x other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Powell Marge Unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pam Baker/Executor of Will 1503 Rising Ridge Road, Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Sign sur of Funeral Service Lice 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to incredent cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last -arcinoma Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. the as use IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ģ 4 Pregnant at time of death Month Year Dav 5 ☐ Other (specify) P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by sign. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 s autopsy performent? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 □Yes 2 □No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IMO am 1000428 20

State

Registrar

31. Date filed (Month, Day, Year)
SEP 0 8 2003

mo ome

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N BRECHER

forti

2101 mel

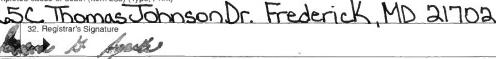
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Frank Stephen Lipieko, Sr. September 14 2008 12:05A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Country Meadows Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 X M 2 □ F Yrs 86 Apr. 2, Director 1922 Pennsylvania 193-12-2378 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Evanther must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 XNo Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5955 Quinn Orchard Rd. 21704 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 No
If Yes, Give
Year or Dates: 1942-45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: ò 3 X Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 crane operator steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Lipieko Veronica Gutowski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Anita Staley/ granddaughter</u> 10409 Green Valley Rd. Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 9/17/2008 Baltimore, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licens Jaria 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a prequence of): heard disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No ed by the detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2**X** No DISEC 1 Yes 3 Probably 4 Unknown been si should t Ortesy Completed YOURN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an has page 2 s r this certificate h 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Living Fac 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending investigation s after dea... rai Director: Aft 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours af the Funeral D mpletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Hiren Shah 31. Date filed (Month, Day, Year) SEP 2 2 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

)0051L43

Eleanor Mays

			Please	Type or Pri				=	_	•
			For State Registrar	State of Ma	-	partment of b Certificate of		-	giene Reg. No. 2 () ()	8 30318
	Physici /Medic		1. Decedent's Name (First, Middle, I	ast)	Ma	45		2. Date of Dea Month	ath Day Yea	
1	Examin Funeral Director		215–14–6938	ne	e (In yrs. last birtha 86 Yrs	Severn    Severn	a Park If Under 24 Hrs. Hours Min.		4c. County of De	eath
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne An	undel	10c. City, Town o	r Location na Park				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the I 23a or 28a st be rould	al Director	10e. Street and Number 267 Tolstoy Lar	ie	<u></u>	10f. Zip Code <b>2114</b>	6		10g. Citizen of What	Country?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If flem Z7 is marked other than "natural", or flems 23a or 28a-f show or other traumatic event, it is Medical Examinar must be notified at or other traumatic event, it is Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 □ If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub 1 □Yes 2 ▼ No	dispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)	14. Race - Ar Black, Wh Specify:	merican Indian, nite, etc. White
1215-0	vithin 72 ho ene. :han "natur inedical	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5	(G	ecedent's Usual Occup iive kind of work done e. DO NOT use retire	during most of wor d)	rking	16b. Kind of Busines Western E	·
$\subseteq$	ild be filed within fental Hygiene. rked other than " ilc event, Il a file	To Be Co	12 17. Father's Name (First, Middle, La Noble Fisher	st)	. I.	Machinis			Maiden Surname) unk	Tectic
, Mary	1 and 2 should Health and Mer iem 27 is marke other traumatic		19a. Informant's Name/Relationship Kathy Holmes/ I		267	Tolstoy I	ane Sev		er, City or Town, State	
timore	Z = e a		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Content of the Content	cify)		sposition (Name of crematory or other pla T Memorial Gardens			20c. Location - City  Davidsonvi	lle, MD
Ba	permit. F Departm Importar any Injur		21. In nature of Juneral Service Lic	Parson	00	495 Gov. R	itchie H	wy, Seve	rna Park,	T
	Physician /Medical Examiner	(	23a Part1. Enter the disease, or co shock or heart failure. List on immediate Cause (Final disease or condition resulting in death)	a. Athero Due to (or as	a consequence of):	c Cardio		_		Approximate Interval Between Onset and Death
90,	s be executed sician and burial-transit	I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	5.05				
	eath certificate attending phy for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome  1  Live birth 4  Pregnant a	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ру		23d. Date of o	delivery Day Year
rds, P.	n requires that the dispersion is the standard by the should be detached	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause giv	en in Part I.		obacco use contribute Yes 2 □ No 3 □	to the cause of death?  Probably 4 Unknown
al Reco		Completed						24a. Was autop perfo 1 □ Yes	osy prior t rmed? death	autopsy findings available to completion of cause of es 2 146
<u> </u>	rnysician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ☐ ER/Outpa	itient 3 DOA Oth	Or:	ath <i>(Check only o</i> lome 5 ☐ Resid	ne) dence 6 □ Other (S	pecify)
Division of Vital Records,	ng ng ther	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Sulicide 6 ☐ Could not determine	be 290 Place of Init	y, Year) Injui	ry Wor	ryat k?  Yes 2 ∐No		now injury occurred  Street and Number or vn, State)	Rural Route Number,
	Hospital 4 hours Funeral tely filled	edical Ce	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examination and/o	eath occurred at the ti or investigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
	No the within 2 To the comple	Me	29b. Signature and title of certification	Dun		29c. Licens	5 7474		29d. Date signed (Mo	
5	CH		30. Name and address of person who Scar Zaft M.D.	completed cause of d	eath (Item 23a) (Type 44)	ne Print)		sadena	September	(172
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 5	2008 32. Fegistra	ar's Signature	Beron Ro		/		
DHM	IH 17 Rev 1/20				- 70	and a				

State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** September 5, 2008 4:50 A M **Evelyn** M. Mosedale /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Larkin Chase Nursing Home Bowie If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11–15–1909 Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 🔀 F Hyattsville, MD 214-36-2694 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at MD Prince George's Hyattsville Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6003 41st Avenue 20782 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event. The status of the status Black. White, etc 1 Never Married 2 Married Specify: White 1 ☐Yes 2X No Specify 2 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ariculture Department Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Goddard Harry Degges ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Croom Airport Rd. Upper Marlboro, MD 20772 Fredric Mosedale 15707 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 9/10/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Rome 21. Signature of Funeral Service 1 x nsee 3401 Bladensburg Road Brentwood, MD 20722 Duha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a Dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus. (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) cate has been signed by the page 2 should be detached Division of Vital Records, P.O. 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š No 3 Probably 4 Unknown Hypertension 1 ☐ Yes Completed General Debility 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 24 No certificate 1 □Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0045217 9/8/2008 30. Name and address of porson who completed cause of death (Item 23a) (Type, Print) Ade I. Ajayi, MD 6201 Green At Road Suite U-15 Greenbelt, MD 20740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 9 2003 Registrer

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			100	rtificate of Death		. No. 2008	30320
	Physici		1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
	Physici /Medio		Robert Marshall		Septembe		18:17 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			
- 1-	Funeral		Washington Adventist Hospital	Takoma Park  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomer 9. Birth	place (State or Foreign
	Director		578-20-3732 1½ M 2□ F 88 Yrs.	Months Days Hours Min.	(Month, Day, Y	(ear) Cou	ntry) land
	pu v		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le				10d. Inside City Limits
	laryla shov	or	Maryland Prince George's Hyattsvi				1/10a. Inside City Limits
	28a-	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Cou	44
	3a or		4922 LaSalle Road	20782		nited Stat	
	ems a	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F		14. Race - Amer Black, White,	ican Indian,
036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, it is Mydical Evaninar must be notified at		1 Never Married 2 Married 1 Never Married 2 No	1 □Yes 2½T No Specify:			Black
<u>5</u>	72 h	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	g   16	b. Kind of Business/Ir	ndustry
7	within ene. than	dmc	Elementary/Secondary (0-12) College (1-4or 5+)			-16 F1	
2	filed I Hygi other ent, I	Be C	8 years Tr	ruck Driver 18. Mother's Name		elf Employ  iden Surname)	ec
/lan	uld be Menta rrked rtic ev	P P	George Clement	Vida St	ewart		
ar,	and Nama is ma			ng Address (Street and Number or Rura		•	p Code)
≥ ش	and and lealth m 27			Riggs Road, NE Was			
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is more fired at any injury or other traumatic event, it is more.	- 1	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. Place of Dispocemetery, cre Harmony M.	matory`or other place)		c. Location - City or T Landover,	
Balt	permit. Departi Importi any inj			2. Name and Address of Facility St 001 Benning Road,			
			23a. Part 1. inter the disease, or complications that caused the death. Do not en shoc 1. heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	i P			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	96.76". \$			
	_xammor	<u>_</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	uted d ansit	Examiner	Cause (Disease or injury	2 Renal dis	2092		
o,	e exec an an rial-tra		that initiated events resulting in death) Last  C. Due to (or as a consequence of)	10109 003	0.000		
68760	death certificate be executed e attending physician and d for use as the burial-transit	Medical	d. Diabells				
9 ×	ding p		IF FEMALE: 23c. If yes, outcome of pregnancy				
Rox	leath ce attendii	Physician/	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	very Day Year
л О	w requires that the dispension signed by the should be detached	hysi	1   Yes 2   No 9   Unknown 9   Unknown				
S, T	iaw requires that the as been signed by the 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
or o	een si				1 ☐ Yes	2 ☐ No 3 ☐ Pro	bably 4 Unknown
<u>မ</u>	has b	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	ician: The certificate hirector, page				performe 1 □ Yes 2 □	d? death? No 1 □Yes	2 🗆 No
<b>=</b>	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ► No Hospital: 1 ☑ Inpatient 2 ☐ FR/Outnatien	26. Place of Death			
0	nding Physician: th. After this certifica funeral director, p	일	27. Manner of Death 28a. Date of Injury 28b. Time o	1 3 DOA 4 Nursing Hon	ne 5 ∐ Residend 8d. Describe how	ce 6 ☐ Other (Speci injury occurred	fy)
VISION	endin ath. or: Aff	atio	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No			
Š	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 2	8f. Location (Street City or Town, S	et and Number or Rur State)	al Route Number,
_	ospita hours ineral ly fillec	OF	29a. Certifier  1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, a	nd due to the cau	se(s) and manner as	stated.
	the H hin 24 the Fi	Medical	(Check only one) 2  Medical Examiner: On the basis of examination and/or in and manner stated.				
	5 V VII	Σ	29b. Signature and title of certifier	29c. License number		. Date signed (Month,	Day, Year)
	2 (2)	-	20 Name and address of parent who completed arms of death (New 20) 77	D6383	7	7/2/0	0
6	12 3		30. Name and address of person who completed cause of death (Item 23a) (Type, Chirumamilla Padma, M.D. 7600 Carrol	, and the second	oma Park	MD 20912	
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature			, 123 20712	
	Registra	12	SEP 0 9 2008 France & Species				

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Etta Selma Miller September 6, 2008 1:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Year) 1□ M 2 🖺 F Director 149-14-1165 83 May 22, 1925 New Jersey Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examination ust be notified at 1 TVes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14514 Homecrest Road Apt. L-2 20906 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Return to Vendor Processor Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isadore Gelfound ဂ္ Rose Moskowitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important; If Item 27 is
any Injury or other trau Alvin Miller - son 102 Hemison Court Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Telmud Torah Cemetery 9/8/08 4 ☐ Donation 5 ☐ Other (Specify) Newark, New Jersey 21. Signature of Funer S rvice Licensee Danzansky-Goldberg Memorial Chapels, 1170 Rockville Pike Rockville, MD 2 Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypoxemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Eisenmegers Syndrome burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical Atrial Septal Defect the attending philogophics are the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☒ No Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □ Ýes 2 🛛 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospital or Attentation.

within 24 hours after death.

To the Funeral Director: Af 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 D65953 September 6, 2008 30. Name and address of person who mple a cause of death (Item 23a) (Type, Print) Adaku Chimtua Onukogu, MD 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 08 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene State
State
RegistrarAMFND#23a(C,d)perMD,9-8=08,PMW,MDDCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Florence Milzman September 3, 2008 12:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill Nursing Home Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 94 Months 1*2*970571913 Maryland 578-48-3765 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XYes 2 No **Funeral Director** MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 6113 Tilden Lane 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 2**X** No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Demolition 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H Harry Hoffman Ida Miller P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Joseph Milzman-Son 6113 Tilden Lane Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Menorah Grdn's 9/5/2008 4 Donation 5 Dother (Specify) Rockville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward\_Sagel Funeral Direction, 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hypercapnia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hypoxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that in list agents. Due to (or as a consequence of): Examine Severe Restrictive & Obstructive Pulmonary Disease iding physician and the burial-tray resulting in death) Last Due to (or as a consequence of):
Restrictive Pulmonary Disease
Chronic Aspiration Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Severe Hiatal Hernia, Osteoporosis, Status-Post 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Respiratory Arrest, June 2008 Twice 24a. Was an autopsy performed? Yes 2X No 2□No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Certification: To 1 ☐ Yes 2X No 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ours after death,
neral Director: A within 24 hours a To the

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, MD

8218 Wisconsin Avenue, Suite 305 Bethesda, MD 20814

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D35579

29c. License number

29d. Date signed (Month, Day, Year)

September 3, 2008

31. Date filed (Month, Day, Year) 0 8 2008

29b. Signature and title of certifier

(Check only one)

Registrar's Signature

State

Registrar

			For State	State	of Maryla	nd / Depa	artment of H	lealth and Death			08	30323
			Registrar  1. Decedent's Name (First, Middle	e, Last)	·		incate or i	Jean	2. Date of Dea	Reg. No.		3. Time of Death
	Physici		Elizabeth Ma	rie Met	zger				Month	Day	Year	M M
Va_	/Medio Examir		4a. Facility Name (If not institution				4b. City, Town, or	Location of Dea		mber 5, 4c. County		3:32 p
			Holy Cross Ho	enital			Silve	r Sprinc	ī		Monto	merv
П	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days		s. 8. Date of Birt	h v. Year)		lace (State or Foreign
н	Director		219-10-0477	1L M 2LAF	88	Yrs.	mentite Baye	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		26, 191		PA
	and t		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	Maryl f sho	ō										1 □ Yes ŽŽNo
	the 28a notif	Director	Maryland Mo 10e. Street and Number	ntgomery		Rockvil	10f, Zip Code			10g. Citizen of	What Cour	itry?
	3a oi	O E	4411 Independ	ence Stro	20+		20853					.,,
	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or items 23a or 28a-f show ent, it is M-dical Evaminer must be notified at	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (	Specify Yes or No-	USA 14. Rad	ce - Americ	
9	after or Ite mine		1 ☐ Never Married 2 ☐ Marri	Armed F	2 KNO		_		rto Rican, etc.)		ck, White, e	etc.
9	ours	d by	3x Widowed 4 ☐ Divorced	If Yes, G Year or I			I∐Yes 2√∑No	Specify:		Specif	y: 1	White
215-0036	72 h 'natu	Completed	15. Decedent (Specify only highes	's Education of grade completed	)	(Give	dent's Usual Occupa kind of work done o	during most of wo	orkina	16b. Kind of B	usiness/Inc	lustry
2	vithin ane. <b>than</b>	dm	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. L	OO NOT use retired	))		•		
72	iled v Hygie ther i		8 17. Father's Name (First, Middle, I	( act)		H	omemaker	19 Mother's No	ame (First, Middle,		n Home	<u>e                                      </u>
ä	e d d	Be C	Walter Skysin:					To. Mother's Na	ime (riisi, middie,	Maiden Surnan	ie)	
Maryland	d 2 should be filed w th and Mental Hygie 7 is marked other t traumatic event, In	은	19a. Informant's Name/Relationsh			10h Mailin	g Address (Street a	and Number or E	Helen Po		State 7ie	Cadal
<u>8</u>			George E. Mei		ì		Independ					
<u>ი</u>	f Healten		20a. Method of Disposition		20b.	Place of Dispos	sition (Name of natory or other place	ì	Date	20c. Location		
e E	Page ent o nt: If ry or		1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		Jale			, ~01	ot. 11		·	
altimore,	permit. Pages 1 and 2 Department of Health s Important; If item 27 is any injury or other tra	Ĭ	21. Signature of Funeral Service I		Od	22	Heaven Cer	s of Facility				ng, Maryland
ñ	permi Depar Impor any ir		1 Chuchen	) West	0	I	rancis J	. Collin	ns Funera	1 Home	Inc.	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	caused the dea	th. Do not ente	rancis J 000 Unive erthe mode of dyin	g, such as cardia	ac or respiratory ar	silver rest,	Sprin	pproximate Interval Between
	Physician		Immediate Cause (Final disease or condition								4	Onset and Death
	/Medical		resulting in death)	a. Cer Due to	(or as a consec	quence of):	ccident				-	
	Examiner		Cognoptially list conditions	b =								
-	p ÷	Examiner	Sequentially list conditions, if any, leading to immediate cause. Unter Underlying	Due to	(or as a consec	quence of):						-
	ecute and	каш	Cause (Disease or injury that initiated events resulting in death) Last	C	(							
700,	icate be executed physician and the buriat-transit		, , , , , , , , , , , , , , , , , , ,	Due to	(or as a consec	quence or):						
ò		dical		d								
XOD	Prystcian: The law requires that the death certificate this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, ou	tcome of pregn	ancv		_		004 0-	4f :1-15:	
ŏ	teath atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	aldeath 3⊑	Ectopic pregnancy Other (specify)	,			te of delive onth	ry Day Year
	the cachec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unk								_
,	s that med I	by P	Part II. Other significant conditio	ns contributing to d	eath but not res	sulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
cords,	quire en siç uld b								1 □ Y	es 2□No	3 ☐ Prob	ably 4 🔀 Unknown
) )	aw re as be 2 sho	Completed							24a. Was a		Were autor	osy findings available
בֿ ן	The I	E						-	autops	med?	prior to con death? 1 ∐Yes	npietion of cause of
<u>.</u>	sian: ertifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of De	t □Yes ath (Check only on		I LI TES	2 🗆 140
5 7	Physician: The law this certificate has al director, page 2.8	2	1 Yes 2 No	Hospital: 1 🔀	Inpatient 2	] ER/Outpatien	1 3 □ DOA Othe	r: 4 🔲 Nursing I	Home 5 ☐ Reside	ence 6 □Oth	er (Specify	()
= [	ding Ph h. After thi funeral		27. Manner of Death  1★★Natural 5 □ Pending	28a. Date (Mor	of Injury oth, Day, Year)	28b. Time of Injury	28c. Injury Work'	at ?	28d. Describe ho	ow injury occurr	ed	
	tendi leath. tor: /	cati	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could no	ation			M 1 □Y	′es 2□No				
5	or At offer of Direct in by	Certification:	4 ☐ Homicide determin	ned 28e. Place	of Injury - At hing, etc. (Speci	ome, farm, stre	et, factory, office		28f. Location (S: City or Town	treet and Numb n, State)	er or Rural	Route Number,
	pital burs a eral I	- 1	29a. Certifier 1 Certifying	Physician, To th	a boot of multime				The second secon			
	Io the Hospital or Attending Pl within 24 hours after death.  To the Funeral Director: After it completely filled in by the funeral	Medical	(Check only 2 Medical E	Physician: To the examiner: On the b	e best of my kno basis of examina iner stated.	ation and/or inv	estigation, in my op	ne, date and plac pinion, death occ	e, and due to the durred at the time, d	cause(s) and ma late and place,	anner as st and due to	ated. the cause(s)
	vithin o the	Me	29b. Signature and title of certifier	01			29c. License	number	2	9d. Date signe	d (Month, E	Day, Year)
	10		> Ushr	1 del	_ 0	0		H64588		Septem		
	G	-	30. Name and address of person w	/ho completed cau	se of death (Iter	n 23a) (Type, F	Print)					
			Ashish Tolia, M				Road, Si	lver Spr	ing. MD	20910		
	Stat		31. Date filed (Month, Day, Year)	32. F	registrar's Signa	ature	N. o					
	Registra	r	SEP 0 8 2	008	wen to	A DEA						

State of Maryland / Department of Health and Mental Hygiene 30324 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jean Sept. E. 2008 1627PM<sup>M</sup> Merriwether /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Mayorth | 1997, 19925 | Pennsylvania 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 194-20-1664 1 □ M 2 🕅 F Director 83 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10c. City. Town or Location 10a, State 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6602 Oak Orchard Ct. 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces

1 Yes 2 1

If Yes, Give
Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Purnell Anne Taliaferro ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JoAnn Merriwether Spearmon 4616 21st. StreetMt. Rainer, MD 20712 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Sept. 6,2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Cicersee Genesal Address of Facility tion & Funeral Services 5732 GA., Ave., Wash, DC Part 1. Enter the discrete or complex tions that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the dis Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Anoxic Encephalopathy attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 X No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 🕅 Natural ours after death.

eral Director: Al filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number D32247 Sept. 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farr, Nooshin 1500 Forest Glen Rd., Silver Spring, MD 20910 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 08 Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.0.

Division of Vital Records,

Physicia /Medic Examin	al
Funeral Director	
D .	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is "Medical Examinat must be nothed any once.

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

ဥ

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

BEATRICE E. NEWELL 9/4/05/1950

Division of Vital Records, P.O. Box 68760,

1 - For State Registrar	State of Ma	ryland / Depar <i>Certi</i>		r Health a of Death	and IV	lental Hy	gien Reg. N	20	0.8	30325
1. Decedent's Name (First, Middle, Las	st)				T	2. Date of De	e <i>a</i> th		00	3. Time of Death
Beatrice E. Newe	11					Septem	ber	<sup>ay</sup> 4,	2008	7:50 PM
4a. Facility Name (If not institution, give	e street and number)	4	b. City, Town	, or Location of	of Death				y of Death	1
Suburban Hospita	1		Bethes						tgome	
5. Social Security Number 6. S		(In yrs. last birthday)	f Under 1 Yea	ar   If Under		8. Date of Bi	rth	, IIOII	9. Birth	place (State or Foreign
023-09-1771	□M 2፟፟፟፟፟	92 Yrs.	Months Day	/s Hours	Min.	0ct. 2	5, rear	915	Mass	pplace (State or Foreign intry), achusetts
Usual Residence of Decedent										
10a. State 10b. County		10c. City, Town or Locat	ion							10d. Inside City Limits
MD Montgome	ry	Chevy Ch	ase							1 AYes 2 No
10e. Street and Number			10f. Zip Code	Э			10g. C	itizen of	What Cou	intry?
8100 Connecticut	Avenue #1	511	2	0815			U	.S.A	•	
11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13. Wa	s Decedent o	f Hispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	)-		ce - Amer	ican Indian,
1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		Yes 224N			, , , , , ,		Specia		ite
3 ☑ Widowed 4 ☐ Divorced	Year or Dates:									
15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deceder (Give kin	it's Usual Occ d of work dor	cupation ne during mosi ired)	t of workii	ng	16b. I	Kind of B	usiness/Ir	ndustry
Elementary/Secondary (0-12)	College (1-4or 5+	)		ired)			١,			
47 Fabrus Name (First Middle 1 and)	4	Kese	archer	10.11.11	1. 1.	457-4 A 41-4-41.		N.I.		
17. Father's Name (First, Middle, Last)						(First, Middle	, maide	n Surnar	ne)	
Harry M. Segal				Minn:						
19a. Informant's Name/Relationship (7						al Route Numb				p Code)
Paul A. Newell -	Son	6660 Do				umbia,				
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disposition cemetery, cremate	on (Name of ory or other p	lace)	Đ	ate	20c. L	ocation.	- City or T	own, State
4 □ Donation 5 □ Other (Specify		Judean Mem	orial	Gdns .	9/7	/08	01n	ey,	Mary.	land
21. Signature of Funeral Service Licen	See	Dan 22. N	ame and Add	ress of Facilit	rg M	lemoria	1 Cl	ape	ls. I	nc.
Donald	Hottles	sees 117	O Rock	ville 1	Pike	Rockv	i111	e, M	D 208	352
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused tone cause on each line	death. Do not enter t	he mode of d	lying, such as	cardiac c	or respiratory a	rrest,			Approximate Interval Between
Immediate Cause (Final disease or condition		enal Failur							Ĭ	Onset and Death
resulting in death)	a.	consequence of):							$\rightarrow$	
0	Hypoten	sion								2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):								<b>,</b>
Cause (Disease or injury that initiated events	c.									
resulting in death) Last	Due to (or as a	consequence of):								
	,d									
200. Was deceder pregnant	23c. If yes, outcome o							23d. Da	ite of deliv	very
in the past 12 months? 1 □Yes 2 🎛 No	4 Pregnant at 1		ctopic pregna ther <i>(sp</i> ec <i>ify)</i>					Me	onth	Day Year
9 ☐ Unknown	9 Unknown									
Part II. Other significant conditions co	ontributing to death but	not resulting in the unde	rlying cause o	given in Part I.		23e. Did 1	obacco	use con	tribute to t	the cause of death?
						10	Yes 2	K No	3☐ Pro	bably 4 🗌 Unknown
						24a. Was	an	24h	Were aut	opsy findings available
						auto		- 1	prior to co death?	empletion of cause of
25. Was case referred to medical							2 🛭 N		1 ☐ Yes	2 □ No
examiner?	Hospital:			thor:		(Check only o				
27. Manner of Death	28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 ∐ DOA   3 28c. In	4 🗆 110		ne 5 Resi				fy)
1 ☑ Natural 5 ☐ Pending	(Month, Day,	Year) Injury	W	ork?	- 1	ou. Describe	now inju	iry occur	rea	
2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		. At home form street		□Yes 2□1		06 1 1 4				
4 ☐ Homicide determined	building, etc.	/ - At home, farm, street, (Specify)	actory, office	8	2	28f. Location ( City or To	street a wn, Stat	ria Numi e)	er or Run	al Route Number,
29a. Certifier 1 A Certifying Phy	valaion. To the best of	many has accorded to the desired		Alama	d = la	and don't st		- \		
(Check only one)	iner: On the basis of e	my knowledge, death of examination and/or inves	curred at the tigation, in m	time, date an y opinion, dea	id place, a th occurre	and due to the ed at the time,	cause( date ar	s) <i>a</i> nd m id place,	anner as and due t	stated. to the cause(s)
29b. Signature and title of certifier	and manner state	90.	200 Line	nse number			204 5	ato ei-e-	d (Manet	Day Yearl
255. Signature and title of certifier										Day, Year)
			D66	990		1	Sat	t ami	her 5	2008

State Registrar

DHMH 17 Rev 1/2001

20

6420 Rockledge Drive #4100 Bethesda, MD 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Vinni Juneja, MD

31. Date filed (Month, Day, Year) SEP 0 8 2008 For State Registrar

1. Decedent's Name (First, Middle, Last)

Certificate of Death

Reg. No. 2008

2. Date of Death

Physician
/Medical
Examiner

SEPTEMBER 15 2008 2:14 pt WILLIAM ROBERT NEWNAM, JR. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Kent Chester River Hospital Chestertown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Apr 23 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 3 1922 **Funeral** Days Hours 1 X M 2 □ F 218-16-6936 86 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a armany injury or other traumatic event, the Martin 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Kent Massey 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13121 Massey Rd. 21650 U.S.A. Funeral 14. Race - American Indian 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1X Yes 2 No 1942 If Yes, Give Year or Dates: —1946 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 XNo White Specify: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Robert Newnam, Sr. Lessle Sutton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Newnam (wife) 13121 Massey Rd. Massey, MD. 21650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Massey Cemetery 9/19/08 4 ☐ Donation 5 ☐ Other (Specify) Massey, MD. 21. Signature of Funeral Service Lice calena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 23a. Pad1 Enter the disease, or complications that caused the death. Do not enter the mod-shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician clersh Rar 46x10v /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence of: Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, aftending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ' autopsy this certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PR/Outpatient 3 □ DOA Certification: To 1 🔲 Inpatient 21 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death. 29a. Certifier cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D. Benjamin, M.D. 6602 Church Hill Rd. Chestertown, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** September 3 Neil 22008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numbe Examiner eorge's Hospital heverly If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 226-04-2610 1 XM 2□ F **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be political 1 ☐ Yes 2 MNo Director 10e. Street and Number 10g. Citizen of What Country? -ittleford U.S. A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Service Elementary/Secondary (0-12) College (1-4or 5+) CDL Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Marian Cleveland Kice Love 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5405Littleford Street Springfield VA 22151 Lovey Perry / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairfax Memorial Pk September 8, 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility

Demaine Funeral Home 5308 Backlick Rd Springfield VA

Angelinate 21. Sign ture of Funecal Service Licensee 23a. Part 1. Enter the diseas shock, or heart failure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Head Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ruck Tree Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) Exami and burial-t Due to (or as a consequence of) Box 68760. attending physician certificate be Physician/Medical the as IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> pe 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed? Yes 22 No certificate 2 🗆 No 1 Yes 1 ☐ Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28d. Describe how injury occurred Decens
UMS cutting down at the law shall are down 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending Injury 0902 M 1. Yes 2 □ No investigation Hugust 29 2008 2 Accident Ane down filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 9299 28e. Place of Injury - At home, farm, street, factory, office building, e.c. (Specify) 9200 4 ☐ Homicide Powder HINRCOOL Beltsville MAR 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 10

State <sup>3</sup> Registrar

31. Date filed (Month, Day, Year) SEP 0 9 2008

SALVADO

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last)  $r^{\text{Day}}1, 2008$ September Da 10:50<sup>P</sup>м **Physician** Peeler Kelly Marie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) **Examiner** Prince George's Heartland Healthcare Center Adelphi If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1□M 2√2F December 12, 1944 577-58-9823 63 **Georgia** Director Usuat Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov other than "natural", or Items 23a or 28a-f show Washington Yos 2 No Director D.C. 10g. Citizen of What Country? 10f. Žip Code 10e. Street and Number 20011 5516 5th St., N.E. U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked Gerolean McCord Robert Cureton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m eny injury or other traum once. 5516 5th St., N.E., WDC 20011 Shernita Morris-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removal from State Lincoln Cemetery 9-10-08 Suitland, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 2504 28th St., N.E., WDC 20018 21. Signature of Funeral Service Licensee Ant 1. There the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vascular Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2☐No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown þ sate has been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 **№** No or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Medical Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Naturai 5 Pending To the Hospitei or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **benimeteb** 4 Homicide 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of Pertifier 29d. Date signed (Month, Day, Year) 29c. License number D0058290 September 5, 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sureshkumar Muttath 5711 Sarvis Ave., Ste. 200 Riverdale, MD 20737 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 9 2008 Registrar

DHMH 17 Rev 1/2001

08-06698 Colin Pollock Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008

		- For State Certification - Ce	ficate of l	Death		Reg.		00 3032
Physicia ledical Examin	n/	1. Decedent's Name (First, Middle,Last)  Colin Sheppert Pollock				September		3. Time of Death
		4a. Facility Name (if not institution, give street and number) 14338 Chesterfield Drive	41	Rockville	Location of Death		4c. County of De Montgomer	у
Funeral Director		5. Social Security Number 216-25-1974 6. Sex 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days			l Fo	Birthplace (State or reign Country) Maryland
any	<u> </u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Locatio	n				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	횽-	Maryland Montgomery Roc	kville	10f, Zip Code		10g	. Citizen of What (	1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Dir.	14338 Chesterfield Road		20853	0.1-1-2/0	- if . Vo. as No.	USA	merican Indian, Black,
or items	Fune	11. Marital Status  1 X Never Married 2 Married Armed Forces?  3 Widowed 4 Divorced or Pates	If Ye		, Mexican, Puerto		White, et	white
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed) 1  Elementary/Secondary (0-12) College (1-4 or 5+)  1	during mo		ion (Give kind of DO NOT use ret		Educat	1.67
ore, MD 21215-0036 s: I and 2 should be filed within 7 of Health and Mental Hygiene. If Item 27 is marked other than her traumatic event, the Medica	Be Com	17. Father's Name (First, Middle, Last)  James Eric Pollock				e (First, Middle, Ma y Lowry		
MD 212 d 2 should b lth and Ment n 27 is mark		19a. Informant's Name/Relationship (Type, Print )	1				er, City or Town, S	Ĩ
imore, MD 2121 Pages 1 and 2 should be finent of Health and Mental 1 lant: If item 27 is marked or other traumatic event,		1 Burial 2 X Cremation 3 Removal from State Me b	ace of Dispositematory or other	tion (Name of ce	metery,		20c. Location - Cit	lle, MD 20853 y or Town, State dria, Virginia
Baltimore, permit. Pages I ar Department of Hee Important: If iten injury or other tr		4 Donation 5 Other Specify:  21. Sign luce of Funeral Service Licensee	50	O Unive	rsity Bl	vd, W.,		oring, MD 2090
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. In failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	of Head	e mode of dying,	such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):						
executed an and al - transit	I Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	:					
al al	/Medical	UNPENDED  XAMENDE #3,28aperME,  IF FEMALE:  23c. If yes, outcome of pregna		MW,Mcco			23d. Date of de	livery
	Physician/M	1   Yes   2   No 9   Unknown   236. If yes, outcome of pregnal at time of deal	2 Fet	al death 3 ner (Specify)	Ectopic pregr	nancy	Month	Day Year
i, P.O. B ires that the d signed by the lbe detached	<u>آھ</u>	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause	given in Part I.			te to the cause of death?  Probably 4  Unknown
cords law requinas been 2 should	Completed		·			24a. Was a autops perform	y pric ned? dea	re autopsy findings available or to completion of cause of with?  Yes 2 No
tal Rec	Bec	25. Was case referred to medical examiner?	2010 1 11111		of Death (Chec		Residence 6	Other: Scene
of Vi	٤	1 V Yes 2 No I mpatient 2 2	ER/Outpatient 28b. Time of Ir		iry at Work?		ow injury occurred	
Division can be strenged by th	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 ✓ Suicide 6 Could not be			Yes 2 V No building, etc.	28f. Location (S	treet and Number	or Rural Route Number, City
Divis  Hospital or A 4 hours after Funeral Dire ely filled in t		4 Homicide determined (Specify) Single Famile 29a. Certifier	e, death occur	red at the time, o	ate and place, ar	nd due to the cause	field Drive , Roc e(s) and manner as	s stated.
To the I	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	d/or investigat	ion, In my opinio	n, death occurred	at the time, date a	and place, and due	to the cause(s)  (Month, Day, Year)
5	Σ	29b. Signature and title of certifier	λ	29c. Licen		ME	September 2	
		30. Name and address of person who completed cause of death (Item 2 Theodore M. King, Jr., MD. Assistant Medical Ex		111 Penn S	treet, Baltimo	ore, MD 21201		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur		£ 8				
Regist	rar	SEP 0 8 2008 Process 18	A TOURS IN	V. Talland				

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 12:26 P Lillian G. Paul September 5, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14508 Homecrest Road Apt. 221 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Oct. 27, 9. Birthplace (State or Foreign Country) New York Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 F 86 Director 078-14-7490 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leaith and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show injury or other traumatic event, the Miclical Expresser must be notified at Director 1XIYes 2 □ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 14508 Homecrest Road 20904 Apt. 221 12. Was Decedent Ever in U.S. Armed Forces? or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Book Keeper Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Goodheim ဂ္ Helen Lask 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Stephen Paul - Son Tuckahoe Court North Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Gdns. 9/7/08 4 Donation 5 Dother (Specify) Olney, Maryland Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee 23a, Part 1, Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 2 months disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Transient Ischemic Attack 1 X Yes 2 No 3 Probably 4 Unknown Hypertension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 □Yes 2 X No 2 No 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident filled in by the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier September 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dawn Broderick, MD 18109 Prince Philip Drive #275 Olney, Maryland 20832 31. Date filed (Month, Day, Year) SEP 0 8 Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

			partment of Health and Me ertificate of Death		ene2 0 0 8	30331
Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  Forrest E. Reid  4a. Facility Name (If not institution, give street and number)		2. Date of Death Month Sept.	Day Year 4, 2008	3. Time of Death
Funeral Director		Fort Washington Hospital 5. Social Security Number $220-16-9657$ 6. Sex $110 \text{ M} 2 \text{ F}$ 7. Age (In yrs. last birthda) $20 \text{ F}$ 92 Yrs.	Fort Washingto    If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.	n 8. Date of Birth (Month, Day, Y 9 / 7 / 1 9	Prince G  9. Birth Cou	eorge 's  place (State or Foreign  ntry)  V A
Maryland a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or MD Prince George's Fort Wa				10d. Inside City Limits 1
th with the 23a or 28	Funeral Director	10e.Street and Number 1800 Palmer Road, #114	10f. Zip Code 2 0 7 4 4	10g	. Citizen of What Cou USA	ntry?
ine; intelly letter Z. I.Z. I.Z. COOO s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If the alth and Mental Hygiene, or Itema 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates: 1942-45	. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F	orfy Yes or No- lican, etc.)	14. Race - Ameri Black, White, Specify: B 1 a	etc.
d within 72 ho giene. In then "natur	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)  Carrier	g	b. Kind of Business/Ir	
should be filed with the Marked of the the marked other than marked other than matter event, the marked other than matter event, the marked other than marke	To Be C	17. Father's Name (First, Middle, Last) George E. Reid	18. Mother's Name		iden Sumame)	
Tand 2 shows the strength and 27 is much be traumant the strength and the traumant the strength in the strengt		Lelah C. Reid/Wife 180	Ding Address (Street and Number or Rural  Description (Name of Discourse)		ANY	o Code)
permit. Pages 1s Department of He Important: if Item any injury or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)  21. Signature of Funeral S vice Liters ge	position (Name of place) amatory or other place) nd Veterans 9/12 22. Name and Address of Facility Str 6500 Allentown R	/2008Ch ickland	neltenham I Funeral	, MD Services
Physician /Medical Examiner Physician and Ph	cal Examiner	23a. Fant1. Enter the disease, or complications that caused the death. Do not estable, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter undaritying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brous after death.  To the Funeral Director: Attenting rectificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	rery Day Year
w requires that been signed by should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to t	the cause of death?
n: The law relicate has ber	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
hysiciai this certi al directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati		e 5 ☐ Residen	ce 6 □Other (Speci	fy)
United the Hospital or Attending Physician: The law within 24 hours after death, to the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	27. Manner of Death    Alatural   5	Włork? M 1 ☐ Yes 2 ☐ No	8d. Describe how	et and Number or Run	al Route Number
pltal or A ours after eral Dire		4 Homicide building, etc. (Specify)		City or Town,	State)	
the Hos	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier	investigation, in my opinion, death occurre	d at the time, date	and place, and due t	to the cause(s)
T With	_	A.M. Abbell	29c. License number 46046	)	Date signed (Month,	
-77		30. Name and address of person who completed cause of death (Item 23a) (Typ. Dr. Amir Mirza Alikhari, 11711	-	Ft,Wash	n.,MD 207	44
Sta Registr		31. Date filed (Month, Day, Year) SEP 0 9 2008				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#4a, POEPHYS G883 Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 20:45 2008 Beulah Viola Rexroade Sept. 13, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Frostburg Village
Frostburg Home 4b. City, Town, or Location of Death Examiner Allegany Frostburg 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1914 **Funeral** Hours Days Min. Maryland 1 □ M 2 🛛 F 213-24-5796 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No MD Director Allegany Frostburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21532 U.S.A. 100 Honeysuckle Lane, Apt. 425 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo Baltimore, Maryland 21215-0036 Specify. White Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Spot Welder Electronics 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Howard Metz Corabelle (Sweitzer) Metz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 408 Rugby Avenue, Brooklyn Park, MD Jeanne Kimery Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Germany, MD Mt. Beulah Meth Cemeter 22. Name and Address of Facility Hafer Funeral Service, P.A. 21. Signature of Funeral Service Licensee 1302 National Hwy., LaVale, MD 23a. Pant 1. Enter the disease, or complications that cays of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hronic Immediate Cause (Final disease or condition resulting in death) Congestive **Physician** years /Medical Due to (or as a consequence of Examiner Due to (or as a consequence of): Ecquentially flat curditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Pleural effusio 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the formula in the formula death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

48 Tarn Terrace, Frostburg, MD

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

S. L. Sandhir, MD,

SEP 2 2

31. Date filed (Month, Day, Year)

9-15-200 8

30333 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 8, 2008 9:57 P. M **Physician** Gerald Lee Reed /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hancock 4212 Resley Road Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 12,1933 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours MD 1X M 2□ F 75 Director 214-30-1788 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location with the Maryland 10a, State 10b County Iteme 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Hancock Washington Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21750 4212 Resley Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Specify: White ŏ 1 ☐ Yes 21 No Specify Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced natural', 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railroad Track Supervisor 1.2 ages 1 and 2 should be filed a part of Health and Mental Hygie it: If Item 27 Is marked other 1 y or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret M. Gladhill ပ္ Jesse Albert Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4212 Resley Road Hancock, MD 21750 Betty J. Reed/Wife 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Pages 1 To Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or gnce. 09/12/2008 Big Pool, MD Parkhead Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 141 West Main Street Grove Funeral Home, P.A.Hancock, MD 21750-0368 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death years tmmediate Cause (Final disease or condition resulting in death) Call LUNG a NOW-SMALL **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tran Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetet dea 4 Pregnant at time of death 2 Fetet death 3 Ectopic pregnancy Year Month Day in the past 12 months? for 5 ☐ Other (specify) ☐ Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2☑No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manger of Death Certification: Hospitel or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. To the I the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and titte of certifier 0 -008 D58117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 WEST HIGH STREET, MAN COCK STAMEY MA Registrar's Signature 31. Date filed (Month, Day, Year) SEP 2 2 State Registrar

DHMH 17 Rev 1/2001

				partment of Health and Mertificate of Death		ne v2008	30334
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	/Medic	al	Thomas Michael Schulz  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	September	2008 4c. County of Death	11:34 Рм
	Examin	er	Mandrin Chesapeake Hospice House	Harwood		Anne Aru	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda $091-16-7483$ 1 $\overline{X}$ M 2 $\Box$ F 86 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea) 02/02/192	9. Birth	place (State or Foreign ntry) York
	Director		Usual Residence of Decedent		02/02/192	.z New	TOLK
	arylan show	٦.	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	rect	Maryland Anne Arundel Annapolis  10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cou	
	th with	ral D	2900 Shipmaster Way, Apt. 317	21401		ited Stat	-
9	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, the thorical Experience in a table notified at	Funeral Director	1 Never Married 2 Married 1 Mayes 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	etc.
Baltimore, Maryland 21215-0036	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII		1Ch	Specify: Whi	
215	hin 72 9. an "na'	Completed	15. Decedent's Education (Specify only highest grade completed) (Giver Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of worki . DO NOT use retired)	ing 160.	Kind of Business/In	dustry
2	ed witi lygiene her tha	Com	4 Corp	orate Salesperson		nsumer Pr	oducts
and	0 = 0 5	To Be	17. Father's Name (First, Middle, Last) Thomas H. Schulz	18. Mother's Name Margaret	e (First, Middle, Maide Lawler	∍n Surname)	
ary	2 should be and Mental is marked of raumatic ev	۲	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or Run		y or Town, State, Zi	p Code)
ა ა	and 2 Health Sm 27 in			Shipmaster Way, A			
nor T	Pages 1 nent of I nnt: If ite iny or of		I Dunal 2 Defination 3 Definition State	ematory or other place)		Location - City or To	
a ⊒	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic ev once.			22. Name and Address of Facility Geo:	6/2008 Edg rge P. Kal	ewater, M	laryland
n	8 3 1 6		1/1/1/1/1/1/1/1/2	973 Solomons Islan	d Rd.,Edge	water, M	21037
in,	hysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Depth
	/Medical Examiner		Due to (or as a consequence of):				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			7.	
	ificate be executed g physician and is the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C				
8/60	ate be nysicia he buri	dical	d				
õ ×	ding pl	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
. Box	death certificate be executed e attending physician and dor use as the burial-transit	hysician/Me	in the past 12 months?  1   Live birth 2   Fetal death 3	B ☐ Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
	that the ed by th detache	Phys	9 ☐ Unknown		D		
cords,	requires the	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1	o use contribute to t 2 ☐ No 3 ☐ Pro	he cause of death? bably 4  Unknown
Hec	The law rate has be	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
	cian: ertifica ector, p	BeC	25. Was case referred to medical examiner?	26. Place of Death	1 □Yes 2 XI n (Check only one)	No 1 □Yes	21200
5	Physician: r this certific ral director, I	၉	1		me 5 Residence 28d. Describe how in		THUSE
0	ath. r: Afte	ation	Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation		20d. Describe flow in	ury occurred	
DIVISION	al or Atters all or after de all Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due t	stated. o the cause(s)
	vithi Comp	M	29b. Signature and title of certifier	29c Nicense number	29d. C	Date signed (Month,	Day, Year)
C	HUH		30. Name and address of person who completed cause of death (Item 23a) (Type	A JANTER OR	mot cos	HOUS V	10.215 CW
	Sta Registra		31. Date filed (Month, Day, Year) SEP 0 5 2008 32 Registrar's Signature	barles		, , ,	V

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:20 A M Ronald R. Schultz, Sr. September 4, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2709 Coxswain Place Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 11/09/1934 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Min Months Days Hours 73 Director 193-26-5822 Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exarchar must be notified at Director 1 ☐ Yes 2 ☐ XNo Anne Arundel Maryland Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2709 Coxswain Place 21401 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 DYes 2 DNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1952-70 þ Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Military Intelligence Specialist United States Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Rudolph W. Schultz Sophie Zawicky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any Injury or other trau Shirley A. Schultz/Wife 2709 Coxswain Place, Annapolis, Maryland 21401 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 09/05/2008 | Edgewater, Maryland 21. Signature of Figure 1 Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to The law requires that the death certificate be executed Due to (or as a consequence of) inding physician ause as the burial burial Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 Unknown 9 Unknown signed by it σ. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 2 □No 1 □Yes of Vital 2 No 1 ☐ Yes or Attending Physician: after death.

Director: After this certification of the funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 8 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of D ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ∏ No 3 Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) **SEP 0 5 2008** Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla	•	artment of F r <i>tificate of</i>		-	giene Reg. No. 20	800	30336
	Physici		1. Decedent's Name (First, Middle, La Mildred	Ann		Stone		2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, gi CIVISTA MED) 5. Social Security Number 6.	ve street and number)	s. last birthday) Yrs.		ATA  If Under 24 Hrs  Hours Min.	h	4c. County CHA	of Death  O C S  9. Birthpl	) ace (State or Foreign
	show det	7.	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo						Od. Inside City Limits
	r 28a-f	Director	Maryland Char.  10e. Street and Number	Les		Walde	orf		10g. Citizen of V	What Count	1 X Yes 2 No try?
	ath with	ral D	1731 Brightwe	ll Court			20602		บร	SA	
036	be filed within 72 hours after death with the Maryland that Hyglene.  ed other than "natural", or items 23a or 28a-f show event, it is the first leave in second at a confined at	by Funeral	11. Marital Status  1   Never Married 2	12. Was Decedent Ever in Marmed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I □ Yes 2XNo	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		e - America ck, White, e	tc.
DRE	within 72 ho ene. than "natur he Medical	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired DMemake	during most of wor d)	king	16b. Kind of Bu		•
192	should be filed wind Mental Hygies marked other tumatic event, in	Be Co	17. Father's Name (First, Middle, Last	9	110	Jiiieiiia Kei		ne (First, Middle,		nesti ne)	<u>C</u>
yar V	should be and Ments s marked umatic er	To E	James	Н	Stor		Grace		C		utler
STONE , Baltimore, Mary	permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 is market any Injury or other traumatte once.		19a. Informant's Name/Relationship  Valerie Stone/ 20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □	Daughter  20b.	1731 Place of Dispo	Brighty sition (Name of natory or other place	ce)	Waldo	rf, Ma 20c. Location -	ryla City or Tov	nd 20602 wn, State
(シ 量)	permit. Po Departme Importani any Injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature				Lal 9/1				ryland PA
Ä	permi Depar Impor any Ir	100	764		91 20	605 Aqı	uasco Ro	d. Aqua	sco, M	aryl	and 20608
	Physician /Medical	5 U/A	23a. Fart 1. Enter the disease, or con shock, or heart ailure. List only Immediate Cause (Final disease or condition resulting in death)	a. Respivo	atory	Failur		or respiratory an	rest,		Approximate Interval Between Onset and Death
	rtificate be executed  19 physician and as the burlat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hemot Due to (or as a conse COPD Due to (or as a conse c. COPS Due to (or as a conse	thorax						
		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregr 1  Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 ☐	l Ectopic pregnanc	у		l l	te of deliver	ry Day Year
rds, F	w requires that s been signed t should be dett	۵	Part II. Other significant conditions	contributing to death but not re	esulting in the ur	derlying cause giv	en in Part I.	23e. Did to			e cause of death? ably 4 🗌 Unknown
Division of Vital Records, P.O	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. The state of the	e Completed	25. Was case referred to medical				26 Place of Des	24a. Was a autop: perfor 1 □ Yes	med?	prior to con death?	osy findings available inpletion of cause of 2 No
- Y	hysici this cer il direct	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 npatient 2	☐ ER/Outpatien	t 3 DOA Oth	or:	ome 5 ☐ Resid		er (Specify	)
sion o	tending Paleath. tor: After the funera	Certification:	27. Manner of Death  ↑ Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	e l	28b. Time of Injury		y at k? Yes 2 □ No	28d. Describe h			
Divi	spital or Attend ours after death neral Director: / filled in by the f	Certifi	4 ☐ Homicide determined	building, etc. (Spec	cify)		(	28f. Location (S City or Tow	n, State)		
	To the Hos within 24 ho To the Func completely	edical	29a. Certifier (Check only one)  12 Certifying Pl 2 Medical Example 1	hysician: To the best of my kn miner: On the basis of examin and manner stated.	nation and/or inv	estigation, in my c	me, date and place opinion, death occu	e, and due to the our erred at the time, o	cause(s) and madate and place,	anner as st and due to	ated. the cause(s)
	vithi To to		29b. Signature and title of Certifier	MD		29c, Licens	e number 005799	j9 <sup>2</sup>	29d. Date signed	Month, E	ay, Year)
S	BO		30 Name and address of person who	completed cause of death (Ite	em 23a) (Type, 1 1637 Te	errace D	rive Ste	103, W	aldorf	, ML	20602.
	Stat	te	31. Date filed (Month, Day, Year)	32. Regionars Sign	nature	Acres .					

DHMH 17 Rev 1/2001

**Funeral** Director

	Chata		-	artment of Heal ctificate of Dea		ental Hy	giene Reg. No. 2	108	3033
	Registrar AVEND#26perMD, 9-8-08, BMW,			tilicate of Det	2011	2. Date of De		300	3. Time of Death
an		NDERS				Month SEPT.	Day 4 . 2	Year 2008	1:50 P M
al er	4a. Facility Name (If not institution, give street and number)	ADLIKO		4b. City, Town, or Loca	ation of Death	DLI I .		y of Death	1.50 1
	9937 GOOD LUCK RD. #202			SEABE	ROOK		PRI	INCE G	EORGES
	5. Social Security Number 6. Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year   If U	Inder 24 Hrs. ours Min.	8. Date of Bi (Month, D	rth		lace (State or Foreign
	246-48-8537 1□M 2\XF	88	Yrs.				10,1920		H CAROLINA
	Usual Residence of Decedent  10a. State 10b. County	10c. City	/ Town or Lo	cation				11	0d. Inside City Limits
Director	NG DODEDWGON	-		DED CDDINGS	7				1 X Yes 2 □ No
2	NC   ROBERTSON  10e. Street and Number			RED SPRINGS	•	f	10g. Citizen of	What Coun	try?
	114 CARRIE LANE			28377	7			U.S.A	
3	11 Marital Status 12. Was Decedent	Ever in U.S	S. 13. \	Was Decedent of Hispan	ic Origin? (Spe	cify Yes or No		ce - Americ	an Indian,
	1 Never Married 2 Married 1 Yes 2 N If Yes, Give	No		f Yes, specify Cuban, Me I □Yes 2 <b>∑</b> No <i>Sp</i>	exican, Puerto i ec <i>ify:</i>	rican, etc.)		ck, White, e	etc.
62.5	3						Speci	BLA	CK
	15. Decedent's Education (Specify only highest grade completed)		(Give	lent's Usual Occupation kind of work done during		ng	16b. Kind of E	Business/Ind	dustry
Completed	Elementary/Secondary (0-12) College (1-4or 5	i+)	me. I	OO NOT use retired) HOUSEKEEPE	70		DOME	ESTIC	
	17. Father's Name (First, Middle, Last)					(First, Middle	, Maiden Surna		
	CHRISTOPHER COLUMBUS	S CH	AMBERS		El	FFIE	EAST	MAN	
2	19a. Informant's Name/Relationship (Type. Print)	011	T	g Address (Street and N					Code)
	ANNIE BROWN/DAUGHTER		121	U ST. N.W.,	WASHI	NGTON.	D.C. 20	0001	
	20a. Method of Disposition	20b. Pl	lace of Dispo	sition (Name of natory or other place)		ate	20c. Location		wn, State
	1X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			CEMETERY	9-11-	-2008	RED SE	PRINGS	, NC
	21. Signature of Funeral Service Licensee	- MOO	0	Name and Address of HAMBERS FUN 801 CLEVELA	Facility NERAL HO	OME & (	CREMATOR	RIUM,P	.A.
	23a. Part1. Enter the disease, or complications that caused							FID. 2	Approximate Interval Between
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as  Due to (or as  Due to (or as	a consequ	ence of):						
Pnysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			171	ate of delive	ery Day Year
2	Part II. Other significant conditions contributing to death by  GANGRENE (2) BIG 701		Iting in the ur	nderlying cause given in	Part I.				ne cause of death? ably 4 Unknown
						24a. Was auto perfo 1 □ Yes		prior to cor death?	psy findings available npletion of cause of 2 No
3	25. Was case referred to medical examiner?				Place of Death	(Check only		d dan	ahter's
ł	1  Yes 2 No Hospital: 1 Inpatie 27. Maryler of Death 28a. Date of Inju		ER/Outpatier		☐ Nursing Hor		idence 6 AOt	her (Specif	"home"
	1 ☑ Natural 5 ☐ Pending (Month, Da. 2 ☐ Accident investigation	y, Year)	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes	1	8d. Describe	how injury occu	rred	
	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide   28e. Place of Injubiliding, etc.	ury - At hoi c. (Specify	me, farm, stre			8f. Location ( City or To	Street and Num wn, State)	ber or Rura	l Route Number,
nicalical o	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis o and manner sta	f examinat	wledge, death ion and/or in	n occurred at the time, do	ate and place, and death occurre	and due to the	e cause(s) and n date and place	nanner as s , and due to	tated. the cause(s)
	29b. Signature and title of certifier			29c. License num	nber		29d. Date sign	ed (Month,	Day, Year)
	curran saver MO			D166	19		SEPTER	UBER	5,2008
-	30. Name and accress of person who completed cause of d	eath (Item	23a) (Type,	Print)	1			-	1-100
9	C. VERGARA - S.O.A.RES 99 31. Date filed (Month, Day, Year) 32. Begistre	40 F	FRANK	Print)	RE D	e. No	TILLEHA	M. A	10.21236
	SEP 0 8 2008	a. o digital	4.	will					

DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON. HOSROW TABASSI 7601 OSLER DRIVE. MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

and manner states

DIL

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-30339 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Month **Physician** 9 Lynn Wade Taylor 2008 8 1:43 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/3/1947 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Min. Months 215-44-7107 61 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it a Modical Eventine is used by a cuttled at once. 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State 1 ☐ Yes 2/CXNo Be Completed by Funeral Director MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11848 Assateague Rd. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕅 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Landscaping 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Alton Wade Taylor Florence Hudson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cora Mae Taylor / wife 11848 Assateague Rd., Berlin, MD 21811 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/12/2008 Evergreen Cemetery Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardiogenic /Medical Due to (or as a consequence of): Examiner acute Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

TOD:0143 PoD 9/8/O8 TOD O Records, P.O. Box 68760, certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Division of Vital ompletely filled in by the funeral director, Medical Certification: To 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 o the lithin 2 o the l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055188 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 733 Healthway Dr Berlin Zabeth 31. Date filed (Month, Day, Year) State SEP 0 9 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

2008

pg a certificate After the

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygienes 30340 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Mattie R. Whitaker 11:22 A M 08 2008 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F Days Hours 85 North Carolina 229-22-2559 June 30,1923 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits TYTYes 2□No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20904 531 Randolph Rd. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: Black 1 ☐Yes 2 No Specify 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doc Sims Hannah Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joyce Palmer/ Daughter 9417 Fontanna Dr., Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 09/06/2008 Silver Spring, MD Gate of Heaven 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC 23a. Part 1. Enter the disease, or & mplic no is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Urosepsis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Enterococcus Due to (or as a consequence of): Uterovaginal Fistula Due to (or as a consequence of): Physician/Medical End of Pelvic radiation, Uterine Cancer IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2√No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 🙀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D67279 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Suganthi Alagarsamy Veerappan 1500 Forest Glen Rd., Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Sigr State SEP 0 9 2008 Registrar

DHMH 17 Rev 1/2001

24 hours

within 2

completely

Amend #1 per ME g884 10/2//08 TT 08-06894 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Leilani Waiters State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Year Lelani Waiters Leilani Waiters **Medical Examiner** 0714 hrs September 9, 2008 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Fort Washington Medical Center Fort Washington Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Min Months Days Hours Director 220 81 5711 2 XX Country) MD М July 11. 2008 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD P.G. 1 Yes 2 XX No Fort Washington notified at once, Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Jaywick Ave, #614 20744 United States 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 XXNever Married African American Yes 2 XXNo If Yes. Give Year 3 Widowed 4 Divorced Specify: narked other than "natural"; cvent, the Medical Examiner 1 Yes 2 XXNo specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 N/A N/A/ h and Mental Hygiene. 27 is marked other th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Brandon Lee Waiters Maria Cristina Y. Lumanan 19a. Informant's Name/Relationship (Type, Print)

Waiters
Brandon Lee Waters (Father) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and M Important: If item 27 is m injury or other traumatic 7200 Jaywick Ave, #614 , Fort Washignton MD 20744 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 XCremation 3 Removal from State Lee Cremtory Sept 15 2008 Clinton, MD Other Specify: Donation 5 22. Name and Address of FacilityLee Funeral Home, Inc 663301d Alexandria Ferry Road, Clinton, MD the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he **Physician** Between Onset and /Medical Death Sudden Unexplained Death in Infancy (SUDI) Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical tending physician are use as the burial - t XUNPENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical the Hospital or Attending Physician; 26. Place of Death (Check only one) funeral director. Be Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: After this ပ 1 ✔ Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Yes 2 X No the f Pending hours after death. unknown Director: 9-9-08 6:00 am 2 Accident Investigation completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7200 Jaywick Ave 61. Fort Washington PG. Co, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be within 24 hours a determined residence 4 Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , M.D O.C.M.E. September 10, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 2 0 Registrar

DHMH 17 Rev 1/2001 OCME 2006 08-06793 Stephen Kim Yee Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hen Kim Ye		State of Maryland / Department of Heart- For State Certificate of Deartman		giene Reg. N	. 200	8 3034
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month Da     September 5	y Year	3. Time of Death 1040 hrs
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or 28	Director	11423 Monterrey Drive	20902		USA	
17215-0036 Id be filed within 72 hours after death with the Maryland Jental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.		Tr. Maritan Otalian	edent of Hispanic Origin? ( Sp			can Indian, Black,
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D 2121 should be fi and Mental I 7 is marked natic event,	ဥ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Addr	ress (Street and Number or R	Rural Route Numbe	r, City or Town, State	e, Zip Code)
Baltimore, MD 21 permit Pages I and 2 should Department of Health and Mc Important: If item 27 is ma injury or other traumatic er				San Franc	cisco, CA 0c. Location - City or	9.4.1.3.4 Town, State
of Hea		1 Burial 2 X Cremation 3 Removal from State crematory or other pla	ser Ser	ot. 7.	50, 200dile. Gily 6.	751111
Page ment tant: or ot		4 Donation 5 Other Specify: Metropolitan	crematory 20	008	Alexandri	a, Virginia
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Medical	(2) 115	failure. List only one cause of each line.				Between Onset and Death
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Box 68760, e death certificate be the attending physic of for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	eath 3 Ectopic pregna	ancy	23d. Date of delive Month	ry Day Year
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Division tal or Attendings after death.  al Director: A led in by the fu	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, fac	ctory, office building, etc.			Rural Route Number, City
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Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 borus after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred a	it the time, date and place, and	d due to the cause(	s) and manner as st	ated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, i and manner stated.	in my opinion, death occurred	at the time, date an	d place, and due to	the cause(s)
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10		Montante Ohne Yhele	O.C.M.E.		September 6, 2	
_		30. Name and address of person who completed cause of death (Item 23a)	Street Deltimore MD	21201		
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08-07193 Joseph Adams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2008 30343

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ne Maryland or 28a-f show fied at once.	ᅂᆫ	Maryland Anne 10e. Street and Number	ALUIK			GIEII B	10f. Zip 0	Code					tizen of Wha	at Country	?
death with the Maryland or items 23a or 28a-f sho must be notified at once.		2005 Preston Ro	12. \		dent Ever in U.S	S. 13. Wa	s Deceden	1060 It of Hisp	anic Origir	n? (Spe	cify Yes or N				n Indian, Black,
	y Funeral	1 Never Married 2 X Mar 3 Widowed 4 Divo	rried 1 1 rced If Yes, or Da	Yes Give Year	ces? 2 X No		es, specify			Puerto R	ilcan, etc.)		White,		e
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21215-0036 Ald be filed within 7 Mental Hygiene. marked other than c event, the Medica	a	William Adams J	r.			I dOb Mailie	e Addross		Jane.			lumber	City or Towr	State 7	in Code)
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  In Director: After this certificate has been sted in by the funeral director, page 2 should be a by the funeral director.	tion: T	27. Manner of Death  1 Natural 5 Pend		Sep 20,	of Injury Day Year) 2008	28b. Time o 1937 hrs	f Injury 2		y at Work es 2 🗸	. 1			injury occur n tree sta		
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Division of Vital Records, P.O. Box 68 within 24 hours after death.  To the Huspital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C		miner:On	To the best the basis of manner st	t of my knowled of examination a ated.	dge, death occ and/or investig	urred at the ation, in my	e time, da y opinion	ate and pla	ace, and curred a	due to the out the time, o	late and	place, and	due to the	cause(s)
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25		30. Name and address of person					11 Dc=			nore A	/D 2120				
	ate	Pamela E. Southall, M 31. Date filed (Month, Day, Year)		400	Medical Exa		Penn	- Stree	ı, baitim	iore, N	/ID 21201	-			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month BURNSIDE SEPTEMBER 18, 2008 00:25 **Physician** PHYLLIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/05/1937 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours **Funeral** 1 M 2 X F MARYLAND 71 213-34-4634 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland or 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director TIMONIUM MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō "natural", or items 23a o 21093 USA 13 KILLALA COURT Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo If Yes. Give Specify: WHITE à 3 Widowed 4 Divorced Year or Dates: permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Execution. Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) ADMINISTRATIVE Elementary/Secondary (0-12) 12YRS College (1-4 or 5+) ASSISTANT ADMINISTRATIVE ASSIST. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PHYLLIS MAE WALTHER HOWARD W. TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JAMES P. BURNSIDE (HUSBAND) 13 KILLALA CT. TIMONIUM, MD. 21093. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

20c. MOUNT CREMATORY 09/20/08 BALTO CITY, MD. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 21111 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner mmuno Suppression Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events Examiner nding physician and use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached in 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Physician: Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA မှ Manner of Death
Natural
Accident . Injury at Work? 28d. Describe how injury occurred Date of Injury 28b. Time of completely filled in by the funeral ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th Certification: 5 Pending investigation (Month, Day Injury 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 
Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated To the I

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 23

UROWSKI

re and title of certific

JASON

29b. Signat

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

KES TOOC

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year,

SEPTEMBER 18. 2008

minde 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 17:50 P M Braxton September iane 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N tomeward If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Ye. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Year 36-1109 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show Examinar coast be notified at Yes 2 No more Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 Married 1 Never Married 1 Yes 2 No ö Baltimore, Maryland 21215-0036 Yes, Give 'ear or Dates: Specify þ divorced 3 □ Widowed 4 □ "natural", Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental JUSE erting 2 Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 1(Sun 68 eboras DERN Ma 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Maunt 09 4 Donation 5 ☐ Other (Specify) Lian 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4600 WBERTYH 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat 20 year Physician a. Chronic obstructive pulmonary resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c, tf ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown premonio Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate 2 No 1 Yes 2 No 1 Tyes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ပို 1 TYes 213 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date ol Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Restane, ATTENDING PHYLICIAL mo D41593 September 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3333 N. Calvert St #650, Battimere 2/18 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		C	ertificate of	Death		Reg. No 2	08	30346
	Division		1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Rashida			Begum		09	23	2008	7:38a. M
The same of	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Dea	ith		ty of Death	
			Gilchrist Hosp:			Tows				ltimo	
	Funeral Director		5. Social Security Number 217-53-0982 6. S	Sex 7. Ag	e (In yrs. last birthda 82 Yrs.	Months Davs	If Under 24 Hrs Hours Min		2 Yea <i>r)</i> 26	Count	lace (State or Foreign try) istan
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					0d. Inside City Limits
	aryla shov	ž	,							"	1 ☐ Yes 2 👿 No
	he M	Director	MD Baltin	nore	Owin	gs Mills			10g. Citizen o	f What Coun	
	3a or 3		10e. Street and Number 211 Isinglass I	ane			117			stan	ily:
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of H		Specify Yes or No		ace - America	
36	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Evaninar must be notified at	by Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X	No	1 ☐ Yes, specity Cub.	Specify:	no nican, etc.)	Spec	ack, White, e cify: Asi	
21215-0036	2 hours	Completed b	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	16a. De	cedent's Usual Occur	pation		16b. Kind of		
218	thin 7 e. an "n Med	ple.	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	life	ive kind of work done e. DO NOT use retire	d)	SIKING			
21	ygien /gien er th	8	N/A	N/A	U	nemploye				emplo	oyed
Maryland	be pd of of of of of of of of of of of of of	To Be (	17. Father's Name (First, Middle, Last	Unknov	vn		18. Mother's Na	ame (First, Middle	, Maiden Surna	<sup>ime)</sup> [	Jnknown
ary	s 1 and 2 should if Health and Mer ttem 27 is marke other traumatic	Г	19a. Informant's Name/Relationship	Type. Print)	19b. Ma	ailing Address (Street	and Number or F	Rural Route Numb	er, City or Tow	n, State, Zip	Code)
Z,	5 = 0 -		Talha Mian-Gran	ndson		Isingla		e, Owing	gs Mil	ls, M	1d 21117
ore	ges 1 ar t of Hea lf item or othe		20a. Method of Disposition  ★D Burial 2 □ Cremation 3 □	I Daman and from Chato	20b. Place of Dis	sposition (Name of rematory or other place	ce)	Date	20c. Location	1 - City or To	wn, State
Ë	nit. Pages partment of ortant: If its injury or o		4 □ Donation 5 □ Other (Special	y)	King M	emorial		/23/08	Woodl	awn,	Md
Baltimore,	permit. Pages Department of Important: If it any injury or conce.		21 Signature of Funeral Service Lice	nsee	N	22. Name and Addre	West	D - 7 + 4		M - 1 0 1	
			23a. Par 1. Enter the disease, or com s ock, or heart failure. List only	plications that caused		300 Waba				Ma 21	Approximate
4	Dharistan		s ock, or heart failure. List only		- 1 -						Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)		a consequence of):	ancel					Months
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0	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):						
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68760,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
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Box	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у			Date of delive Month	ery Day Year
0	The law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician	1 ☐ Yes 2 MNo 9 ☐ Unknown	9 Unknown	it time of death	J L Other (specify) _					
о, С	that ned b deta		Part II. Other significant conditions	contributing to death b	ut not resulting in the	e underlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
Records,	quires in sign uld be	Completed by	coemany ante	my disc	StC_			_ 10	Yes 2 No	3☐ Prob	oably 4 Unknown
S S	law require as been si 2 should b	olete		1				24a. Was		. Were autor	psy findings available
æ	The la	E O						- auto perfo 1 □ Yes	psy ormed? 2 ☑ No	prior to cor death? 1 □ Yes	mpletion of cause of
ita/		Be C	25. Was case referred to medical				26. Place of De	eath (Check only		11163	2010
<b>&gt;</b>	dies X	70 E	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 🗍 ER/Outpa	tient 3 DOA Oth	ner: 4 🗆 Nursing	Home 5 Res	idence 6 🕅	ther (Specify	nhospire
n 0	ng Pł fter tł neral	Ľ.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ry, Year) Injur		ry at 'k?	28d. Describe	how injury occi	urred	
Sio	Attending r death. ector: After by the funer	atic	2 ☐ Accident investigatio	n			Yes 2□No				
Division of Vital	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location ( City or To	(Street and Nur wn, State)	n <i>ber</i> o <i>r Rura</i>	al Route Number,
_	Hospital or 24 hours afte Funeral Dir tely filled in			nysician: To the best							
	the Hohin 24 the Fu	Medical	one)	miner: On the basis of and manner st				curred at the time			
	To To Cor	2	29b. Signature and title of certifier			29c. Licens	se number	,	29d. Date sign		
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	2		30. Name and address of person who		1 211 01	pe, Print)	ST	Tousand	MM		
	Sta	to	31. Date filed (Month, Day, Year)	S2. Regist	rar's Signature	Commen	۷ د	, 0, 2, 7, 0, 0	/ ///		
	Sta Registr		SEP 23		was It	Sparke					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death ecedent's Name (First, Middle, Last) Month **Physician** /Medical Facility Name (If not institution, give street and number) 4b. City, of Death Examiner Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 6 06 Year) 30 Social Security Number **Funeral** Days Months 1 M M 06 78 VA 217-24-8058 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experiment at the mutfilled at 1**X**Yes 2 ☐ No **Funeral Director** Baltimore MD NA 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 1208 H. Cherryhill Road 21225 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 □XNo Specify: þ 3 X Widowed 4 ☐ Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Housewife House 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maggie Mitchell Hayes Jones ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau 1208 H. Cherryhill Road, Baltimore, Eugenia Foster-Daughter Md Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/24/08 Baltimore, Md Cedar Hill 21. Signatule of Funeral Service Licenses Marken ant Antes west 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear bailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** almon disease or condition resulting in death) /Medical to (or as a consequence of) Examiner ONDIGO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 1 TYes 2 No 4 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel

Registrar

3

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death

2008

32.

tem 23a) (Type, Print)

+61/V

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 10:49 AM September 21,2008 /Medical 4b. City, 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Medical Center BALTIMORG

Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12-27-1941 Bayvien Johns Hookins 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ X 2 □ F 212-40-8108 Director NC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be nutified at Director 1 X Yes 2 □ No Baltimore Dundalk MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8321 Kavanaugh Road 21222 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No White Specify Specify: 3 Notidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welding Fabricator Manufacturing Maryland permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Ruth Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Junior\_C. Baine, Jr.-Son 8321 Kavanaugh Road, Dundalk, MD 21222 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 9-25-08 Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature - Funeral Service kilo Dette PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 TYes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation ours after death.

eral Director: A
filled in by the fu 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

SEP

TRISHENA

MD

32. Registrar's Signature

JONES, M. D. 600 North Wolfe Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

eptember 21, 2008

Physici	an	1. Decedent's Name (First, Middle, Last)  Earl Raymond Bell		2. Date of Death Month September 3, 2008	3. Time of Death  5:45 AMM
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		
Examir	ier	Alfred House	Rockville	Montgon	
Funeral Director		5. Social Security Number  5. Social Security Number  6. Sex 10 M 2 F  7. Age (In yrs. In Security Number)	ast birthday) If Under 1 Year If Under 24 H Months Days Hours M	Irs. 8. Date of Birth (Month, Day, Year) 9. 8 04/10/1921	rthplace (State or Foreign ountry) NE
of Health and Mental Hygiana. I flem 27 is marked other than "natural", or items 23s or 28s-f show r other traumatic avent, tra Medical Examinar must be notified at	To Be Completed by Funeral Director	10e. Street and Number 3701 International D  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12 College (1-4or 5+)  13 William Earl Bell  19a. Informant's Name/Relationship (Type, Print)  Imogene Bell/spouse  20a. Method of Disposition  20b. Print	rive #730  10f. Zip Code  2	(Specify Yes or Noerto Rican, etc.)  10g. Citizen of What Control Cont	Prenican Indian, ite, etc.  white solution unk  Zip Code) 2090 pring, MD
Department of P		1 □ Burial 2 □ Cremation 3 □ Hemoval from State 4 ☒ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 23a, Part. Enter the dispase, or complications that caused the death	22. Name and Address of Facility State Anatomy Bo Baltimore, MD	pard 655 W. Baltimo: 21201	re Street
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	e Completed	Congestine Weart For Onema, GERD. 25. Was case referred to medical	Celfelne	24a. Was an autopsy profit of the profit of	autopsy findings availate completion of cause of s 2 1 No
sath. or: After this he funeral di	cation: To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 E  27. Manner of Death 1 Autural 5 Pending 2 Accident investigation  2 Striction 6 Could not be	ER/Outpatient 3 DOA Other: 4 Nursing 28b. Time of Injury M 1 Yes 2 No	g Home 5 ☐ Residence 6 ☐ Other (Sp 28d. Describe how injury occurred	Assistan ecify) Living
rac by	edical Certifica	4 Homicide determined 200. Place of injury - At no. building, etc. (Specify 29a. Certifier 1 Dentitying Physician: To the best of my know	riedue, death occurred at the time, data and ob-	28f. Location (Street and Number or In City or Town, State)	ne state 1
hours efta uneral Dir ily filled in l	É	one) and manner stated.	on and/or investigation, in my opinion, death oc	29d. Date signed (Mor	nth, Day, Year)
within 24 hours eftar de To the Funeral Directi completely filled in by t	Mec	29b. Signature and title of certifier of Lauless	D 25410 23a) (Type, Print) Suite 202, 18111	Sepleate	5200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 06:00 AM NEZ CLARK 09 18 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death saltimore oina Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Hours Months 1 M 2 10.14.1940 ø Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 ☐ No more 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ ★6
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) avrs Marylanc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number 20c. Location - City or Town, State iarl 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Daurial 2 ☐ Cremation 3 ☐ Removal from State Holy hedgerer 9.23.2008 Baltimore MD 22. Name and Address of Facility Vaugna C. Greene Ference Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses MOI 4905 York And Baltimore, MD 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 9NO+16 ENCEPHALOPATHY Due to (or as a consequence of): DISTASE RUNARY Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4. Unknown 1 Tyes

**Physician** /Medical Examiner

sician and burial-transit

attending physician for use as the buris

ed by the

cate has been signed page 2 should be det

funeral director,

filled in by

completely

Medical

The law requires that the death certificate be executed

the Hospital or Attending Physician:

24 hours after death. Funeral Director: A

within 24

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

a or 28a-f show t be notified at show

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Health tem 27 I

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

To Be

Exami Physician/Medical þ Be Completed Certification: To

Sequentially list conditions. ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00064533

alma-TRIC

AVENUE

29d. Date signed (Month, Day, Year)

HOSPITT-

MD21215

State Registrar

BABATUNGE 31. Date filed (Month, Day, Year) SEP 2 3 2008 23

29b. Signature and title of certifier

29a. Certifier

(Check only

2434 W BELVEOGRE M) 32. Registrar's Signature

and manner stated.

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

ATTENDING

PHYSICIAN

			1 - State of Maryland / Dep	partment of Health and I ertificate of Death	_	ene 2008	30351
	Physici	an	1. Decedent's Name (First, Middle, Last)  Carlo Louis Crispino		2. Date of Death Month September	22 2008°	3. Time of Death 7:55 A M
- North	/Medid Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
and i			7 Ruxton Green Court	Towson		Baltimore	
	Funeral Director		5. Social Security Number 214-26-5858 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthda 78 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, ) June 15, 1	rear)   Co	hplace <i>(State or Foreign</i> untry) ryland
	ow III	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	a-fsh		MD Baltimore Towson	า			1 □ Yes 2 🔀 No
	or 28		10e. Street and Number	10f. Zip Code	10g	J. Citizen of What Co	untry?
.036 	eath v	eral	7 Ruxton Green Court	21204	a sife Van a si Na	U.S.A.	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Madical Eventhal Instituted at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ★ Married Forces?  1 ★ Married Forces?  1 ★ Married Forces?  1 ★ Married Forces?  1 ★ Married Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 🏿 No Specify:	Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
2-0	72 hc 'natur	etec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ding 16	b. Kind of Business/	Industry
7	within ene. than	Completed	College (1-40r 5+)	Fing Contractor		Constructi	on
д 2	e filed Il Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
/lar	uld be Menta arked aric ev	일	Louis A. Crispino	Grace	T. Marsh	nall	
Jar	2 sho			ling Address (Street and Number or Rui			
e,	1 and Healt em 27	l à	RoseMarie/Wife 7 F  20a. Method of Disposition 20b. Place of Disp	Ruxton Green Court		c. Location - City or	21204
OE .	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory`or other place)		monium, M	
Baltimore, Maryland 21215-0036	permit. Departn Importa any Inju			22. Name and Address of Facility Ruc 1050 York Road	k Towson	Funeral H	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	mas cul concer			Onset and Death
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	usit nsit	Examiner	Sequentially list conditions, if any, leading to inhimediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.				
o	incate be executed physician and sthe burial-transit		that initiated events resulting in death) Last c. Due to (or as a consequence of):				
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٥ ×	ding p	an .	IF FEMALE:				
O à	unes that the death certificate be executed is signed by the attending physician and diedeched for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of deli Month	very Day Year	
ords, P	gned t	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ord	equire sen sij			-	1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
al Kecords, "The laurenties?"	within 24 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Completed			24a. Was an autopsy performed 1 □ Yes	prior to o	topsy findings available completion of cause of
VITAI	s certif	Be	25. Was case referred to medical examiner?  1 ☐ Yes 3 No Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpatie	0.00	h (Check only one)		
	grring ter this neral d	2 : 1	27. Manner of Death 28a. Date of Injury 28b. Time	HIL 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how	e 6 Other (Specinjury occurred	cify)
VISION	or: Aff	atio	1) Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	Mork? 1 ☐ Yes 2 ☐ No			
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he Hoen	nin 24 hot the Fune	Medical	29a. Certifier (Check only one)  CertifyIng Physician: To the best of my knowledge, deal contained in the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
Ę	To	2	29b. Signature and title of certifier	Print) N. Cliavin	29d.	Preuses	Day, Year)
1	5+1		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) N. Cleavier	ST TO	HSON M	1)
	Stat Registra		31. Date filed (Month, Day, Year) SEP 2 3 2008	uli			
		01					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0 2008 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oakcrest Baltimore Baltimore f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 10, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 X M 2 □ F 85 1923 213-12-8385 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Blvd. 21234 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status I ☑ Yes 2 ☐ No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I and 2 should be filed within 7 lealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Professional Golfer Golfina 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert B. Clarke Ruth N. Pearce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4441 Norrisville Rd. White Hall, Md. 21161 Mrs. Joy Ostrowski/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Co. 9-27-08 Towson, Md. 4 □ Donation 5 □ Other (Specify) 2. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Funeral Service Licenses 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any cause of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequen Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cementa 1 ☐ Yes 2∏ No 3 Probably 4. ☐ Urrknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 100 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Continued in the cause | Co 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

RAW KING

8800 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of confile

29d. Date signed (Month, Day, Year) OX

08-07114 Patrick Joseph Citroni

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 30353

		1- For State Registrar		(	Certifica	ate of	Death			Re	eg. No.		
Physicia	in/	Decedent's Name (First, Midd	lle,Last)		10.1			CH	2	. Date of Deat Month			3. Time of Death
ledical Exami	ner	Patric	k J. Citr	oni	-				ursen a	Septembe	r 18, 2008	11	0755 hrs
		4a. Facility Name (if not institute University Hospital	on, give street and nu	umber)		41	D. City, Town, o	r Location o	of Death	Set le	4c. County of	of Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In	rs. last birt	thday)	If Under 1 Ye	ar If Unde	er 24Hrs.	8. Date of Bir	th(MM/DD/YYYY		
Director		218-21-2849	1XM 2 F		29	Yrs.	Months Da	ys Hours	Min.	Jan.	9, 1979	Foreign Cou	ntry) Maryland
any.		Usual Residence of Decedent  10a. State 10b. County		100	City, Town	or Locatio	n						10d. Inside City Limits
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aryla 8a-f	둟	10e. Street and Number			· · · · · · · · · · · · · · · · · · ·		10f. Zip Code			1	0g. Citizen of Wh	nat Count	ry?
th the Maryland 23a or 28a-f sho notified at once	Director	5402 Edmonds	on Avenue				2122	9			USA		
with is 23;	<u>.</u>	11. Mantal Status	12. Was Dec	cedent Ever	in U.S.	13. Was	Decedent of H	-	gin? ( Spec	cify Yes or No		- Americ	an Indian, Black,
leath item	Funer	1 X Never Married 2 N	larried Armed F	orces?	No	If Ye	s, specify Cuba	n, Mexican,	, Puerto R	ican, etc.)	White	e, etc.	
ffer d	<u>ک</u>	3 Widowed 4 Divorced If Yes, Give Year			40	1 Yes 2 X No specify:					Specify:	Whit	e
ours a atura Camir		15. Decedent's Education (Spe	ecify only highest gra	de complete			s Usual Occup				16b. Kind of Bu	siness/In	dustry
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15-C		17. Father's Name (First, Middle						18.Mother	's Name (I	First, Middle, I	Maiden Surname	)	
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relations Adrian Citron	, , , , ,		- 1						nber, City or Tow		
, MD and 2 sho ealth and em 27 is raumati	-	20a. Method of Disposition	I - Fati				ion (Name of co			; Cator Date	nsville,		
Ore Ses 1 a of Hi	- 1	1 X Burial 2 Crematio	n 3 Removal fi	rom State	cremat	tory or othe	er place)	,				,	
Lim Pag ment tant:		4 Donation 5 Other S	pecify:		A11 S		s Cemet		9-22	2-2008	Reister	stow	n, Maryland
Baltimore, MD 21215-00. permit. Pages I and 3 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other ti injury or other traumatic event, the Mec		21. Signature of Funeral Service	11/16 11		,	Fu:	me and Addres neral H	ss of Facility	f Cai	rling / tonsvil	Ashton S Lle. Inc	chwa	b Witzke
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		past 12 months?	Live	birth nant at time			al death 3 er (Specify)	Ectopic	c pregnan	СУ	Month	Di	ay Year
Box 68760, e death certificate be ex the attending physician ed for use as the burial	hysicial	1 Yes 2 No 9 Un	known 9 Unkn		,	J Oth	er (Specily)				13		
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/ita ysicia nis ce direct	Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	2 ER/O	utpatient		Other <sub>4</sub>		Home 5	Residence 6	Other:	
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ivision  or Attence after death Director:	<u>[2</u> ]		stigation 28e. Plac	e of Injury -	At home, fa	arm, street	, factory, office	building, et	.c. 2			er or Rur	al Route Number, City
Div Spital o	Certification:			Local S	treet				E	or Town, S dmondson A	<sup>State)</sup> Avenue at Upla	nds Par	kway, Baltimore, MD
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical C		hysician: To the beaminer:On the basis	of examinati									
To To Com	Mec	29b. Signature and title of certification	and manner s	stated.	,			se number			29d. Date sign		
		7.1.	1111	,54	/	7	0.0	.M.E.			September	19, 20	008
	}	30. Name and address of persor	who completed cau	se of death	(Item 23a)	(	J						
4			Assistant Medic			11 Penn	Street, Ba	Itimore, M	MD 212	01			
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P.O.

To the Hospital or Attending Physician: s efter deas. ral Director Aff filled in by within 24 hours To the Funeral

State Registrar

VIACGREGOR,

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

September 22, 2008

30. Name and address of person who completed cause of dea h (Item 23a) (Type, Print)

700 W. 40th STREET, BALTIMORE, MD 21211 MIRABELLE

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month. Physician C. Arthur Douglas Sr. Hember 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner If Under 1 Year 5. Social Security 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 XM 2 □ F 412-16-5886 87 Tennessee May Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland | Baltimore Middle River 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 1 Silver Maple Court 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 [**X**Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 years Ship Carpenter Port of Baltimore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Philip Douglas Lvdia Petre ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trainonce. Arthur Douglas Jr. son 4 Silver Maple Court, Middle River, MD. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus Cem. 26, 2008 Dundalk,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licenses 7110 Sollers Point Road, Dundalk, Md. 21222 complications that caused the death. only one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 TYes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural
2 Accident Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division or Vital Records,

The law requires that the death certificate be executed the burial-tran attending physician for use as the buria been signed by the should be detached page 2 s Attending Physician: director, funeral After death. Director: vd ni ō Hospital To the Funeral

hould be filed within 72 hours after of Mental Hygiene.
marked other than "natural", or ite

Baltimore, Maryland 21215-00.

1 and 2 should be

Pages 1

State Registrar

Medical

29a. Certifier

31. Date filed

(Check only one)

29b. Signature and title

VASILIADE, M-D

05

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

20064755

21/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 30356 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** be 3:00 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Elkridge If Under 1 Year If Under 24 Hrs. Woodland torest Drive itoward 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 DF Months Days Hours Min. 579-36-3298 Director November 10, 1929 Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Marylar "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Tes 2 □ No Funeral Director ITOWar 10e. Street and Number 10g. Citizen of What Country? USA torest 21075 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit, Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or ite may injury or other traumatic event, the Modical Extensiones. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: Black δ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service 1-ocd 12 cok 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be aucom ျှ Herman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) st Dr. Manning Woodland Hermoine Elkridge Fore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Itanover 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 10220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arrest Cardiac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Metastatic Colon CANCER months signed by the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 □Yes 2 █No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours a To the Funeral D 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Candace Chandler MD 9-19-08 D29209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CANDACE CHANDLER 7070 Samuel Morse Drive Columbia MD 21046 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 2 3 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 21 2008 **Physician** Dese1 September Peggy 2:45 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1922 Lismore Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth OCT 111328 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral 79** 1 □ M 2 XF NY 126-26-9785 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho 1 TYes 2 XNo Director MD **Baltimore** Catonsville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1922 Lismore 21228 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ş 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education . Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If Item 27 is marked other ti Jury or other traumatic event, In other 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last, William Lane Margaret Farley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. once. Fred F. Desel - husband 1922 Lismore, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 9/22/2008 Baltimore, MD 21. Signature of Feneral Sersice icensee H. Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 ☐ Yes 21 No Completed peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy 1 □Yes 2 No e Hospital or Attending Physician: '24 hours after death.
e Funeral Director: After this certifica letely filled in by the funeral director, p Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Cilect Retukiolotimos/4 mo 212 Lp 1 KAUW 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 23 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30358 1 - For State Registra Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 056 M TEKSUN 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bella Machre Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 MM 2□ F Yrs 259-03-9923 60 Director JUL 17 1948 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 3a or 28a-f show show 1 □Yes 2 No Director MD Anne Arundel Millersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a 233 Severn Road 21108 Funeral USA or Items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 ia marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Specify à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Nursery Worker Sheltered Workshop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Atticus Dye ဥ Gladys Flinn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Seminloe Avenue, Catonsville, MD Gayle Pomeroy - sister 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/19/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e.g. in line. Approximate Interval Between Onset and Death Immediate Cause (Final PIR Physician ATION disease or condition resulting in death) /Medical Due to (or as a con a guence of): Examiner 110 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit Box 68760, 64 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{D Residence} \) 1 Yes 2 No 6 Dother (Specify) WACLINE Medical Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Magner of Death 28d. Describe how injury occurred Division 1 Natural
2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a Certifier 🕰 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19,2008 Name and address of person who completed cause of death (item 23a) (Type William A. L. L. F. A. M. 44 EFENSE ALGINA ANNAPOLIS MINNYO, MICHAEL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 23

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** >: 55 AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, 5–14–1935 Birthplace (State or Foreign Country) (In vrs. last birthday) **Funeral** 96x 120 M 2 □ F Months Days Hours Min. 215-30-7723 Director MD Usual Residence of Decedent death with the Maryland r show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, it a life alocal Experience must be notified at 1XiYes 2 □ No Director n/a MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5006 Patterson Avenue 21215 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 2 Specify. African 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "nr any injury or other traumatic event, it a 1 and once. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City School Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျ Junius Dullev Arlene Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5006 Patterson Avenue, Balto. MD 21215 Cathleen Taylor-Didley/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 9-19-08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Wile Harral Rome F.A. of Palto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any office the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to the as a consequence off-The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Day Month Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown r this certificate has been s ral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 Ng Yes 2 □ No 1 Tes. To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) octor 2 Hospital: Other: 4 Nursing Home 5 Residence 1∐Yes nospice 2 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death within 24 hours after used...

To the Funeral Director: After formulately filled in by the funer. 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Monthy Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

30. Name and eddress of person who completed cause of death (it

2008

Year)

31. Date filed (Month, Day,

m 23a) (Type, Print)

32. Registrar's Signature

		Pleas amend #10a-f Pe 1- For State Registrar	State of M	arýlanď/ I							00000		
		1 - Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)					Dealli	Reg. No. 2 3 3 3 3 5 2 2. Date of Death 3. Time of Death				J	
Physicia		1.22						Month	Day	Year 1, 2008	0215 M		
/Medica		Marianna Derezir  4a. Facility Name (If not institution, s		1	4b.	City, Town, o	or Location of Death	Septemb	_	County of Deat		_	
LAAIIIII	61	Atlantic General	l Hospital			erlin			W	orceste	er		
Funeral		Social Security Number 6		ge (In yrs. last bi	Mo	nder 1 Year		8. Date of Bird (Month, Da	th y, Year)	9. Birt	hplace (State or Foreign untry)		
Director		215–30–4528	ILM ZUF	93	Yrs.			11/18/	1914	Pol	and	_	
and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evandret is ust be nutflied at		Usual Residence of Decedent  10a, State 10b, County  MD Woces		10c. City, Tow	n or Location						10d. Inside City Limits	-	
Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evarring must be notified at	tor	MD Woces Delaware Sussex	ter	Betham							1 □Yes 2 🔀 No		
DE L	Director	40 - Otro of and Normalian	Ocean Pky		10	I. Zip Code			10g. Citiz	zen of What Co	untry?	_	
Nat o		39923 Ayres Road	1-#12	0220		19930	21811		Unit	ed Stat	es		
	Funeral	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣	Ever in U.S.	13. Was I If Yes	ecedent of I specify Cub	Hispanic Origin? (Spe oan, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	<ol> <li>Race - Ame Black, White</li> </ol>			
1	by F	1 ☐ Never Married 2 ☐ Married 3 🗷 Widowed 4 ☐ Divorced	1 ∐Yes 2 ZA. If Yes, Give Year or Dates:	No	1 □ Y	es 2 <b>X</b> No	Specify:		į,	Specify: Wh	ite		
		15. Decedent's		16a	. Decedent's				16b. Kin	nd of Business/	Industry	-	
-	ple	(Specify only highest (Secondary (0-12)	grade completed)  College (1-4or 8	5+)	(Give kind of life. DO N	of work done OT use retire	during most of worki	ng					
셤	Be Completed	12			partme	nt Mar		<del></del>			Property Management		
	Be (	17. Father's Name (First, Middle, La	st)						rst, Middle, Maiden Surname)				
	ပ	Ignacy Rausch	(T. D.)	100			Anna Bai		0.4	T 04-4 1	Zin Onda)		
		19a. Informant's Name/Relationship		1			t and Number or Rura						
1		Bozenna Eastburn 20a. Method of Disposition	ı – Daugnte	20b. Place o	1923 At Disposition	/YES K (Name of	oad Bethai	ny Beac Date		ELaware cation - City or		-	
		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Place of cemeter Saint	sry, crematory Stan:	or other pla Lslaus	nce)	6/2008	Dal+:	imoro	Maryland		
ej		21. Signature of Funeral Service Lic		Cean			ess of Facility Peber Fune:				матутани	-	
any injury or o	Ų.	Music K	X		401	s. Che	ster Stre	rai Home et Balt:	es P. imore	.A. e, Mary	land 21231		
sician edical miner		23a httl Inter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequence	(a)	1 CC		or respiratory a	Trest,		Approximate Interval Between Onset and Death		
١	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einst underlying Cause (Disease or injury											
	=	that initiated events resulting in death) Last	cDue to (or as	a consequence	of):								
	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						2	3d. Date of del	ivery	*	
	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☑ ★6 9 ☐ Unknown	1 ∐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal death it time of death	h 3 ∐ Ecto 5 □ Oth	pic pregnan er (specify) _	cy			Month	Day Year		
	<u>۾</u>	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the underly	ing cause gi	ven in Part i.				the cause of death?		
	ě							24a. Was	00	Odb Word ou	topov findings available	-	
	(D)							autor		death?	topsy findings available completion of cause of		
	mple										2 100		
	e Completed	25. Was case referred to medical	D				26 Place of Doot	1 □ Yes	2 40	1 ∐Yes			
	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 100	Hospital:	ent 2∏FR/Ω	utpatient 31	DOA Ott	26. Place of Death	1 □Yes ∩ (Check only o	2 ANO				
1	Be	examiner? 1 Yes 2 100  27. Manner of Death	28a. Date of Inju	ıry 28b.	utpatient 3 (	J DOY	her: 4  Nursing Ho	1 □Yes ∩ (Check only o	2 No ne) dence 6	☐Other (Spe			
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funeral director, page 2	Certification: To Be	examiner?  1 Yes 2 Do  27. Manner of Death  1 Hatural 5 Pending investigat  2 Accident 6 Could not determine  4 Homicide 1 Certifying	28a. Date of Inju (Month, Date)	ury - At home, fac. (Specify)  of my knowledg	Time of Injury Marm, street, fa	28c. Inju Wo 1 Ctory, office	her: 4 Nursing Ho	1 ☐ Yes  (Check only of the following o	2 Mo ne)  dence 6 now injury  Street and vn, State)  cause(s)	Other (Sperioccurred	cify) ural Route Number, s stated.		
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runeral director, page z	edical Certification: To Be	examiner?  1 Yes 2 16  27. Manner of Death 1 Activat 5 Pending investigat 3 Suicide 6 Could not determine  29a. Certifier (Check only one)  1 Certifying 2 Medical Expending 1 Medical Expending 1 Pertifying 2 Medical Expending 1 Per	28a. Date of Injuided 28e. Place of Injuided 28e. Place of Injuiding, et	ury - At home, fac. (Specify)  of my knowledg	Time of Injury Marm, street, fa	28c. Inju Wo 1 Ctory, office	her: 4 Nursing Ho  ry at rk?  Yes 2 No  lime, date and place, opinion, death occurr	1 □ Yes   (Check only of the control of the cont	2 LMo ne)  dence 6 now injury  Street and cause(s) date and 29d. Date	Other (Spe occurred  d Number or Ru  and manner as place, and due	cify)  ural Route Number,  s stated. to the cause(s)  h, Day, Year)		
in 24 hours after death.  The Funeral Director: After this certifute in by the funeral director pletely filled in by the funeral director.	edical Certification: To Be	examiner?  1 Yes 2 16  27. Manner of Death 1 Activat 5 Pending investigat 3 Suicide 6 Could not determine  29a. Certifier (Check only one)  1 Certifying 2 Medical Expending 1 Medical Expending 1 Pertifying 2 Medical Expending 1 Per	28a. Date of Injuid (Month, Date of Injuid (Month, Date of Injuid Ing., et al.	ury - At home, fac. (Specify)  of my knowledg of examination at ated.	Time of Injury N  Arm, street, fa  e, death occur  nd/or investig	28c. Inju Wo 1 Ctory, office	her: 4 Nursing Ho  ry at rk?  Yes 2 No  lime, date and place, opinion, death occurr	1 □ Yes  ∩ (Check only o  me 5 □ Resid 28d. Describe the 28f. Location (s) City or Tow  and due to the red at the time,	2 Mo  ne)  dence 6  now injury  Street and  cause(s)  date and  29d. Date	Other (Spe occurred  Number or Ru and manner a: place, and due e signed (Monti	cify)  ural Route Number,  s stated. to the cause(s)  h, Day, Year)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year aulline Dunston /Medical 18 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bultinore 6009 Update NO 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-20-7469 1□ M 2**V** F Months Vrs Director 11-26-1915 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lidury or other traumatic event, in Modical Evancinal Trust be notified at ance. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 PYes 2 □ No ALTIMONE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No þ 3 Midowed 4 Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 gRADE HOUSE KOOFER Worken OMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JG551E HETTIE KEMP 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BROWDA 4009 BALTIMONE MD 21207 07 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBASTUS MEM PACK! 5 ☐ Other (Specify) DEPT 25 2018 ARBUTUR Signiture of Funeral Service Licensee 22. Name and Address of Facility
Betts Fineral Home
1129K. CARO (ine ST. m1)21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Chronic Obstructive 2008 resulting in death) /Medical Due to (or as a consequence of): Examiner Stroke 2003 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 2002 The law requires that the death certificate be executed burial-transi Altherners Due to (or as a consequence of) physician sthe burial Division of Vital Records, P.O. Box 68760, Physician/Medical 2002 Diabeto use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☑ No 1 ☐ Yes 2 🗆 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 D Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the ! and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

MANEXLOONS

Michaelle

31. Date filed (Month, Day, Year) SEP 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Holnes

32. Registrar's Signature

D46676

1838 Greene Tree Rd

Pillesville mazzo8

08-07108 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Eric Dozier, Sr. 2008 30362 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Y September 17, 2008 1636 hrs Medical Examiner ERIC DTICK 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore A 4034 Hillen Road 9. Birthplace (State or If Under 1 Year If Under 24Hrs. August 20.1959 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Director Country) 216-68-6632 1 M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State Yes 2 28a-f show BATTIMORE Director 10g. Citizen of What Country 10f. Zin Code 10e, Street and Numbe 4034 4.5,4 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status White etc. Armed Forces? 1 Never Married 2 after death Yes Specify: Black If Yes. Give Year Yes 2 No specify: Widowed Divorced 3 event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours inent of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) KeTKIC GRADE Nonz 18.Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) marked KenA DOZICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rd. BAKO. M) 2122 archase If item 27 Vueen's 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Saltimore, Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee Home BeTTS FUNERAL atricia Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or mart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical X AMENDER 23a, 27, PerME; 6884, 10/8/08, TT X UNPENDED attending physician or use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? certificate has performed? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: Inpatient 2 DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: X Natural Yes 2 No Pending Director: d in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 18, 2008 O.C.M.E. 30. Nome and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Pay, Yeer) 08 32. Registrar's Signature State Registrar

DOME

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Pay 19, Year 2008 September 4b. City, Town, or Location of Death 4c. County of Death

1. Decedent's Name (First, Middle, Last) **Physician** Vincent J. Duquette 10:00A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 508 Gun Road Relay Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ★ M 2 □ F 017-14-5141 90 Director July 22,1918 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Maryland 1 □ Yes 2 X No Director Relay 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 508 Gun Road USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates:1958–59 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No þ Specify. 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 h Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If them 27 Is marked other thi
any injury or other trainmant Airplane Mechanic Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Delphis O. Duquette 2 Rosella DesRoches 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Donoghue - Daughter 508 Gun Road; Relay, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Massachusetts National 9/26/2008 Bourne, Massachusetts 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign Mire of Funeral S. The Ucer 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastate 4m /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate ! performe 1 ☐ Yes 2□ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Certification: To Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated.

To the I within 2 29b. Signature and title (x) 30. Name and address of person who completed cause of death (Item Hen My 31. Date filed (Month, Day, Year) State Registrar

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

23a) (Type, Print)

900

Amend #5, perFh g885 11/6/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death i) EAN **Physician** Month MARIA Ž. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7548 Old Telegraph Road Apt.321 Hanover Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 06-04-1912 6. Sex 9. Birthplace (State or Foreign Mary Tand 216-05-83788379 96 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Anne Arundel Maryland Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7548 Old Telegraph Road Apt.321 21076 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Haslbeck Elizabeth Lang ပ္

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 Is marked other any injury or other traumatic event, # **Physician** 

**Funeral** 

Director

28a-f show

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"natural", or items 23a hours after death

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 in nent of Health and Mental Hygiene.

Examiner must be notified at

he Medical

/Medical Examiner

burial-trar

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ed by the detached

Physician/Medical

Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

or Attending Physician:

this

After

after death

To the Funeral

Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Examiner

So unitially is multilines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

Viene

Mr. Dennis B. Miller - Son

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Ligensee

Marles

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

31. Date filed (Month, Day,

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death 9□Unknown

32. Registrar's Signature

Due to (or as a conseque co

Due to (or as a consequence of)

Due to (or as a consequence of):

3 □Ectopic pregnancy 5 ☐ Other (specify)

15209 Destiny Road

22. Name and Address of Facility

Leonard J. Ruck, Inc.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

23a. Part 1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail e. List only one cause on each line.

Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown

23d. Date of delivery

20c. Location - City or Town, State

Parkville, Maryland

Approximate Interval Between Onset and Death

Year

24a. Was an perform 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 that (Spectry) 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

09/20/2008

New Freedom, PA 17349

5305 Harford Road

Baltimore, Maryland 21214

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be determined

Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 HAER

DEFENSE HOHWAY ANN APULIS MOZINU 441

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 30365 Certificate of Death Reg. No ZUUO 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 19 2008 NORMAN **EVANS** 6:10 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | 01/17/1924 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 1 → M 2 → F 7. Age (In yrs. last birthday) Months 217-14-9998 MD 84 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No PRINCE GEORGE'S MD GREENBELT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Q LAUREL HILL ROAD 20770 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Mayes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **ANNOUNCER** RADIO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JOSEPH ABRAHAMS** NETTIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOLLY EVANS / DAUGHTER 3908 BENTON STREET N.W., WASHINGTON, DC, 20007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State HEBREW YOUNG MENS 09/22/2008 BALTIMORE, MD 4☐Donation 5 ☐Other (Specify) Signature of Funeral Service Lines 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRACRANIAL HEMORRHAGE Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? THROMBOCYTOPENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Û Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗗 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Marylanc

Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other that any injury or other traumatic event, it a gince.

Baltimore, Maryland 21215-0036

/Medical

signed by the attending physician and d be detached for use as the burial-transit

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

Vansinorman

cate has been sign page 2 should be To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page

3

Medical

Exami Physician/Medical ۵ Completed Be Certification: To

6 Could not be

09/16/2008 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NURSING HOME

and manner stated.

9:10 PM

1 ☐ Yes 2 No

FELL OUT OF WHEELCHAIR

28f. Location (Street and Number or Rural Route Number, 6121 MONTROSE RD, ROCKVILLE, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of

29c. License number

29d. Date signed (Month, Day, Year)

30. Name an address of person who correleted cause of death (Item 23a) (Type, Print)

NATASHA P. HAAG MD 8600 OLD GEORGETOWN RD., BETHESDA, MD

31. Date filed (Month, Day, Year) State SEP 2 3 2008 Registrar

3 Suicide

29a. Certifier

4 T Homicide



			1 – For State Registrar		of Marylar		artment o rtificate o				Reg. No.	2008	30366
	Physicia	an	1. Decedent's Name (First, M Milton	_		Fen]	Logis			2. Date of De Month	Dav	Year	3. Time of Death
	/Medic		4a. Facility Name (If not instit	Lee	number)	rem		n, or Location		Septemb		2, 2008 County of Death	12:30 P M
	Examin	er	603 Aldworth	ution, give street and	namberj			dalk	or Death			altimore	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under		8. Date of Bir (Month, Da	th	9. Birthp	lace (State or Foreign
	Director		220-20-0991	1 X M 2 □ F	8:	2 Yrs.	Months Da	ays Hours	Min.	Septembe	ř 19,	1926 Mary	yland
	and w		Usual Residence of Deceden 10a. State 10b. Con		10c, Ci	ty, Town or Lo	cation					110	0d. Inside City Limits
	Maryl	tor		timore		Dundal!							1 □ Yes 2 XNo
	n the	irec	10e. Street and Number				10f. Zip Cod	de			10g. Citi:	zen of What Coun	itry?
	thin 72 hours after death with the Marylan an "natural", or items 23a or 28a-f show	Funeral Directo	603 Aldworth				21	222				USA	
	er dea	nue	11. Marital Status	Armed	ecedent Ever in U Forces?	.S. 13.	Was Decedent If Yes, specify (	of Hispanic Or Cuban, Mexical	igin? (Spen, Puerto	ecify Yes or No Rican, etc.)		14. Race - Americ Black, White, e	
30	rs afte	by F	1 ☐ Never Married 2 🔀 3 ☐ Widowed 4 ☐ Divo	If Yes,	s 2 ∏ No Give r Dates:		1 □ Yes 2 🔀	No Specify:				Specify: Whi	te
9500-61	2 hou atura		15. Dece	edent's Education		16a. Dece	dent's Usual Oc	ccupation			16b. Kir	nd of Business/Inc	dustry
7	hin 7.	Completed	Elementary/Secondary (0-1	ighest grade complete  (2) College	d) e (1-4or 5+)	life.	kind of work do DO NOT use re	etired)	it of worki	ing			_
7	be filed within 72 hours after death with the Maryland at Hygiene. d other than "natural", or items 23a or 28a-f show event, the Assical Eracinar must be notified at		12 years			Patte	ern Mak					lehem St	.ee1
	ed all be	Be	17. Father's Name (First, Mid Anthony Fenlo							e (First, Middle, Fenlock		Surname)	
	2 should be and Menta is marked raumatic ev	၉	19a. Informant's Name/Relat			19b Mailii	na Address (Str					Town, State, Zip	(Code)
	o ± C. F		Elnora Fenloc		е	603	Aldwort	h, Dunc	lalk,	Maryla	ind	21222	oue,
	es 1 a of He of He rothe		20a. Method of Disposition	аПа 14	20b. I	Place of Dispo	sition (Name or natory or other	f place)	Septe	mber	20c. Lo	cation - City or To	wn, State
Ĕ,	Pages ment of ant: If Its ury or o		1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe	on 3 ∟ Hemoval fro er (Specify)	m State Bay	view C	remator		27,2		Balt	imore, M	aryland
Daltimol	permit. Pages 1 and 2 should Department of Health and Mer Important: If flem 27 is marker any injury or other traumatic once.		21. Signalure of Furieral Services	vice Licensee	onnel	ly ?	Name and According 110 Sol	funess of Facili Funera lers Po	l Ho	me Of D Road, D	unda unda	lk,P.A. lk,Md. 2	1222
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F	hysician		Immediate Cause (Final disease or condition	_a. M	ctasto	rtic	Mal	ynai	nt	Mela		ma	Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a conseq	juence of):	A.	J					
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-	d ansit	Examiner	Sequentiany liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>*</b>	<b>y</b>	1-4							
׆	an an rial-tra		resulting in death) Last	C	to (or as a conseq	juence of):							
0 / 00,	Priystolan: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	lical		d									
Ŏ	ling p	Physician/Med	IF FEMALE:										
מ	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 Liv	outcome of pregna re birth 2  Feta	aldeath 3	Ectopic pregn				2	3d. Date of delive Month	ery Day Year
5	y the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Ur	egnant at time of or known	death 5L	Other (specif)	v)					
L	s mar ned b e deta	by Pr	Part II. Other significant con	ditions contributing to	death but not res	ulting in the u	nderlying cause	given in Part I		23e. Did to	obacco u	se contribute to th	ne cause of death?
cords,	quire; en sig uld be									1 🗆 \	res 2	No 3□ Prob	ably 4 🗆 Unknown
ב כ	as be	plet								24a. Was		24b. Were autop	psy findings available mpletion of cause of
ב ז =	rne cate h page	Completed								autop perfo 1 □ Yes	rmed?	death?	
VILC	certific ector,	Be	25. Was case referred to med examiner?				_		of Death	(Check only o			
5 8	r this ral dir	۲.	1 ☐ Yes 2 No 27. Manner of Death		☐ Inpatient 2 ☐ te of Injury	ER/Outpatier	IL 3 L DOA	Other: 4 \(\sum \) Nu Injury at	ursing Ho			Other (Specify	1)
5 5	th. th: Afte	tion	1 Natural 5 ☐ Per		onth, Day, Year)	Injury		Work? 1 □ Yes 2 □		28d. Describe h	iow injury	occurred	
	r dear ector by the	ifica	3 ☐ Suicide 6 ☐ Co	uld not be 28e. Pla	ce of Injury - At he	ome, farm, str			-	28f. Location (S	Street and	d Number or Rura	I Route Number,
5 5	al Dir	Certification:	4 ☐ Homicide de	bul	lding, etc. (Specif	Ty)				City or Tou	vn, State)		
in Coll	To the <b>Propriat</b> of <b>Attending Priysican:</b> The law requires that the death certificate be executed within 24 hours after death. <b>To the Funeral Director:</b> After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Cert (Check only one) 1 Cert	ifying Physician: To i ical Examiner: On the and m	he best of my know basis of examina anner stated.	owledge, deat ation and/or in	h occurred at th vestigation, in r	ne time, date ar my opinion, dea	nd place, ath occurr	and due to the red at the time,	cause(s) date and	and manner as si place, and due to	tated. the cause(s)
Ę	within comp	M	29b. Signature and title of cer	tifier			_	ense number			29d. Date	e signed (Month, I	Day, Year)
	T		Xha	tah				5646	56		91	22/08	
	8		30. Name and address of per	son who completed ca	use of death (Item	n 23a) (Type,		all Di		101-1	241	1	1112000
			31. Date filed (Month, Day, Ye	Par) HU	Registrar's Signa	zu C	anypa	45	V9	whit	e Mi	wesh "	W 423
	Stat Registra		SEP 2 3	2008	De St	GOOM	20						

ORIGINAL

			For State		State of Ma	ryland / [		rtment of H rtificate of L		Ment			~ ~ ~	00000
			Registrar  1. Decedent's Nam	ne (First, Middle, Las	et)		Oei	incate of i			ate of Deat		008	3. Pime of Death
	Physicia		ANDREV	_			FRE	DERICK		N	lonth C	l d	Year	5:44 AM
	/Medic Examin			(If not institution, give				4b. City, Town, or		h			nty of Deatl	
				khill Pl	ace	(In yrs. last bir	thdov)	Nottin	ngnam If Under 24 Hrs	. BD	ate of Birth		9. Birt	hplace (State or Foreign
	Funeral Director		5. Social Security I	1	ex 7. Age LXM 2□F		Yrs.	Months Days	Hours Min.	11	ate of Birth Month, Day - 23 -	1934	ME	untry)
-	σ		Usual Residence	of Decedent										10d. Inside City Limits
	show	'n	10a. State	10b. County		Notti								1 □X es 2 □ No
	28a-f	Director	MD 10e. Street and Nu	Baltin	юте	NOCCI		10f. Zip Code			1	0g. Citizen	of What Co	untry?
	3a or	٥		khill Pl	ace			212	36			USA		
	ems 2	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (5 an, Mexican, Puer	Specify Y	res or No-		Race - Ame Black, White	rican Indian, e, etc.
30	s after	by Fu		rried 2 Married 4 Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:			1∐Yes 2∐ <b>X</b> No	Specify:			Spi	ecify: Wh	nite
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ano	O TO TO	Be C		e (First, Middle, Last) Freder					Helen				,	
2	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	으		Name/Relationship (		198	o. Mailir	ng Address (Street	and Number or R	ural Ro	ite Numbe	r, City or To	wn, State, 2	Zip Code)
Ž	all all all all all all all all all all		Doris M	M. Frede:	rick-Wife			Parkhil			lotti	_		
aitimore,	Pages 1 a nent of Hea int: If item iry or othe			isposition 2 <b>Ϫ</b> Cremation 3 ロ n 5 ☐ Other <i>(Specif</i> )		20b. Place of cemeter Bayv	of Dispo ery, cren ieW	sition (Name of matory or other place Cremat	ory 9-1	Date 19-(	8 8		-	Town, State e, MD
Bait	permit. Pages Department of Important: If i any Injury or once.		21. Signature of	Funeral Service Licen	1300		22	2. Name and Address	ss of Facility B1	rad]	Lev-A	Ashto g Roa	n Fu	neralHome 1222
			23a. Part1. Enter	r the disease, or compeart failure. List only	plications that caused one cause on each lin	the death. Do								Approximate Interval Between Onset and Death
	Physician		Immediate Cause disease or condit	e (Final tion	. Met	astal	Te.	hung	2 Conc				N. A.	26 menth
	/Medical Examiner		resulting in death	"	Due to (or as a	a consequence	of):	0						
		e.	Sequentially list of	conditions,	b. Due to (or as a	a consequence	of):							
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09/89	physicate by the p	edical			d									
BOX	death certif e attending d for use as		IF FEMALE: 23b. Was decede	ent pregnant	23c. If yes, outcome			☐ Ectopic pregnand				23d	. Date of de	
O.		Physician/M	in the past 1 1 ☐ Yes 2 9 ☐ Unknow	2 🗆 No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)					Month	Day Year
J.	requires that the veen signed by th hould be detache				contributing to death bu	ıt not resulting i	in the u	nderlying cause giv	ven in Part 1.		23e. Did to	bacco use	contribute to	o the cause of death?
Sp	quires in sign uld be	d by								.	1 📈 Y	es 2□N	lo 3□P	robably 4 Unknown
Vital Records,	law rea as bec 2 shor	Completed									24a. Was a		4b. Were a	utopsy findings available completion of cause of
ř	The ate h	E O									perfoi 1 □ Yes	med?	death?	s 2 No
VIta	iclan: certific	Be	25. Was case refe examiner?		Hospital:			Oth	26. Place of Dener:					
ō	Physer this eral dil	5	1 ☐ Yes 2 ☐ 27. Manner of De		28a. Date of Inju	nt 2 ☐ ER/O ry 28b.	Time o	nt 3 LI DOA	4 LI Nursing	_		ience 6 L		ecify)
<u>0</u>	ath. r: Afte	ation	1 Natural 2 Accident			y, Year)	Injury		rk? ]Yes 2 □No					
Division	or Atte after de Directo in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		rry - At home, for c. (Specify)	arm, sti	reet, factory, office		28f. l	ocation (S City or Tow	Street and N vn, State)	lumber or R	lural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director,	ledical Co	29a. Certifier (Check only one)		hysician: To the best of miner: On the basis of and manner sta	f examination a								
	To the within To the somple	Mec	29b. Signature ar	nd title of certifier	, , / /	2		29c. Licens	- 0 :			29d. Date s	igned (Mon	th, Day, Year)
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	10+1		30. Name and ad	ddress of person who	completed cause of d		1	Print) Paven	Blud	Ba	e Ho	Me	12	1239
ì	Sta Registr		31. Date filed (Mo	onth, Day, Year)		ar's Signature	16	1 0						
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sep **Physician** GROSS noma BOYd 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Howard HOSPITAL 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 □ F Months Director 534-46-7569 Washington Usual Residence of Decedent 10a. State 10c, City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modeal Exan, in a rough be nutified at 1 ☐ Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8540 High Ridge Road Funeral 21043 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1965–68 1 ☐ Yes 2 No Specify à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Technical Engineer Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Boyd Gross ပ္ Dorothy Maurer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.3
Department of Health a Important: If item 27 Is any injury or other trau Dina Gross - wife 8540 High Ridge Road, Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 
Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/20/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License <sup>2</sup>Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) TCHYS /Medical Due to (or as a conseque of of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): ng physician and as the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year P.O. I 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 ☐ Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 Dres 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? this certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 🗖 No 1 Inpatient မှ 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year) D0058779 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10840 Little ON 31. Date filed (Month, Day, 32. Registrar's Signature Year. State

DHMH 17 Rev 1/2001

Registrar

2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State O Registrar		rtificate of Death	Mental Hygie: Reg.	0000 00070
ı	Physici	an	1. Decedent's Name (First, Middle, Last)  Walter	Gregory,	Ir	2. Date of Death September	3. Time of Death er 20, 2008 1:30P M
4	/Medic Examin		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of Deat	7	4c. County of Death
	Funeral		1049 Armistead Way  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Baltimore Ci		9. Birthplace (State or Foreign
	Director		214-54-2522 <sup>1</sup> <sup>™</sup> <sup>2□</sup> F	57 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Pay, Ye NOV 4, I	950 Pennsylvania
	yland		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits
	he Mar 28a-f s	ector	Md .	Balt	timore City	Tion	1ŽYes 2 No
	h with t	a Dir	1049 Armistead Way		10f. Zip Code 21205	Tog.	Citizen of What Country? U.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Evan, m. I. uist be neithed at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes  1 Yes, Gi  7 Year or D	2X No ve 1	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer l □Yes 2 <b>™</b> No <i>Sp</i> ecify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
2-0	72 hou 'natura dical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	16b	b. Kind of Business/Industry
21215-0036	within jene. r than	Completed	Elementary/Secondary (0-12) College (1	-4or 5+)	OO NOT use retired) Cutter		Printing
	be filed y tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)		1	ne (First, Middle, Maio	den Surname)
Maryland	should nd Mer marke ımatic	은	Walter Gregory, Sr.  19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	Fran g Address (Street and Number or Ri		
	1 and 2 should be f Health and Mental I em 27 Is marked o ther traumatic eve	19	Pamela W.Gregory (w	ife) 1049	Armistead Way	Baltimo	re,Md. 21205
Baltimore,	. Pages 1 ment of H tant; If ite lury or ott		20a. Method of Disposition  ★○  **Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	Holly H		4-2008Mi	ddle River, Md.
Ball	permit. Pag Department Important: I any injury o once.	01 19	21. Signature of Funeral Service Licensee	112	<u>201 Dundalk Av</u>	enue Bal	Funeral Home, P.A. timore, Md. 21222
		e a	23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final			c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	or a consequence of):	Leukemia		One year
	Examiner	<u>.</u>	Sequentially list conditions, b.	or as a consequence of):			
	cuted	Examiner	Cause (Disease or injury that initiated events	or as a consequence on.			
,09	rificate be executed by physician and as the burial-transit		resulting in death) Last Due to	or as a consequence of):			
68760,	rtificate ng phys as the	fedical	d				
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit.	Physician/IV	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing to de	eath but not resulting in the un	iderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death? 2  No 3 Probably 4 Unknown
al Records,	ian: The law re rtificate has be itor, page 2 sho	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 1 Yes 2 1 No
Vital	ysician is certifi director,	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ □	npatient 2 ☐ ER/Outpatient	Other	ath (Check only one)	e 6 ☐ Other (Specify)
on of	ling  After uner	ion: To	27. Manner of Death 1X Natural 5 □ Pending (Mon.	<del>-</del>	28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how in	
Division	Atten deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place buildi	of Injury - At home, farm, stre ng, etc. <i>(Specify)</i>		28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical C	(Check only 2 Medical Examiner: On the b	best of my knowledge, death asis of examination and/or inv ner stated.	occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	0.		30. Name and address of person who completed caus	e of death /Itom 22c) /Time 1	D 0052391		September 22, 2008
	'2		Mark Levis 1650 C	irleans street	Rainz43 Balt	More Maryl	land 21231
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 3 2008	egistrar's Signature	E)	,-	

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Plea	_	_						. Ensur				-	€.		
		For State			State o	of Ma	arylan				∃ealth a⊦ <i>Death</i>	nd M	ental Hy				0.0	O **** I
		Registrar  1. Decedent's Name	e (First, Middl	le. Last)					erunca	ale oi	Dealii	Т	2. Date of D	Reg. No	200	8	3. Time	of Death
Physicia /Medic		John Ma			Sr								Month September	Day 22	•		2:00	Ам
Examin		4a. Facility Name (/				umber)			4b. Ci	ty, Town, o	r Location of				County of D			
		4006 Kah				7 4		to a 4 b i a4b ata		ottir der 1 Year	gham   If Under 24	4 Hrs T	8. Date of B	inth	Bal			or Foreign
Funeral Director		5. Social Security N 216-01-42		6. Sex	M 2□ F		i (in yrs. i	last birthda Yrs.	Month		Hours	Min.	(Month, D	lay, Year)	9.	Coun	ylano	
		Usual Residence of	f Decedent	l									02/13/	1310				
h the Maryland or 28a-f show	or	10a. State	10b. County	imor	^			y, Town or tting								19		City Limits s 2 X No
the N	Director	10e. Street and Nur		TIIIOT			NO	ctriig		Zip Code				10g. Cit	tizen of What	Coun	try?	
th with 23a or	al Di	4006 Ka	hlston	Roa	d					212	236			l	J.S.A.			
items	Funeral	11. Marital Status		12	. Was Dec	cedent E	Ever in U.	S. 1	3. Was De	edent of h	Hispanic Origi an, Mexican,	in? (Spe Puerto I	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, W			
rs afte	by F	1 ☐ Never Marri 3 🛣 Widowed			1 <b>X</b> Yes If Yes, G Year or □	2□N live I9	42 <b>-</b> 19	45	1 □Yes	2 <b>X</b> ) No	Specify:				Specify:	√hi	te	
2 hour			15. Deceden	nt's Educa	tion			16a. De	cedent's U	sual Occu	pation	. 6		16b. K	ind of Busine	ess/Inc	lustry	
ithin 7 ne. nan "n	Completed	Elementary/Seco	cify only highe ondary (0-12)	st grade d	College (		+)	life	e. DO NOT	use retire	,		ng			_		
iled w Hygier ther ti nt, in	S	17. Father's Name	/First Middle	l ast)				Sh	<u>eet M</u>	etal_	Worker		(First, Middle		Surname)	Con	tract	or
ental ked o	To Be	John G		Lucy									C. Ke					
and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show for traumatic event, the "Notical Examination in the Incilling	-	19a. Informant's Na	ame/Relations	ship <i>(Typ</i> e	e. Print)			19b. Ma	ailing Addre	ess (Street	and Number	r or Rura	l Route Num	ber, City o	or Town, Sta	te, Zip	Code)	
and 2 lealth m 27 I		Linda My		Daugi	hter						urt, S				2178	·		
ages 1 nt of F : If ite		20a. Method of Disposition 1 X Burial 2	Cremation		noval from	State	Du 20b. P	lace of Dis emetery, c	position (A rematory o Vall I Gar	iame of r other pla <b>⊖V</b>	ce) 0	_	7-2008		ocation - City MiOniul			and
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the "Motcal Exagnes."		4 ☐ Donation  21. Signature of Fu			, /	)	Mer	hôrta	1 Gar 22. Name	dens and Addre	ess of Facility							
permi Depar Impo any Ir once		1750	Ilm.	10	14	W	MI	1			k Road						204	1110.
		23a. Part 1. Enter t shock, or hea	the disease, or art failure. List	r complica only one	tions that	caused each lir	the death	n. Do not	enter the m	ode of dyi	ng, such as c	cardiac c	or respiratory	arrest,			Approxim Interval B	ate etween
Physician		Immediate Cause disease or condition resulting in death)	(Final on	a.		54	yn	lic	Con	dim	10/	200	ry			(	Onset and	Death
/Medical Examiner		recording in death			Due to	(or as	a consequ	uence of):								0	,	
n +	ner	Sequentially list confrant, leading to imcause. Enter Under Cause (Disease or that initiated events	nditions, imediate	<b>b</b> .	Due to	(or as	a consequ	uence of):										
be executed ician and burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	injury	С.	Due to	/22.22										$\perp$		
	<u></u>	recurring in decision		l.	Due to	(or as	a consequ	uence of):										
death certificate to attending physicate to the ast the b	ledic			d.														
tth cer tendir rr use	an/N	IF FEMALE: 23b. Was deceden in the past 12		230	o. If yes, ou		of pregna		3 □ Ectopi	c pregnanc	cy				23d. Date of	delive	ery Day	Year
he dez	Physician/Medic	1 ☐ Yes 2 [ 9 ☐ Unknown	□No		4 ☐ Preg 9 ☐ Unk		t time of d	leath	5 Other	(specify) _					WOTH		Day	Tour
s that t ned by s detac	y Ph	Part II. Other signif	ficant conditi	ons contr	ibuting to d	death by	t not resu	ulting in the	underlyin	cause giv	ven in Part I.		23e. Did	tobacco	use contribu	te to th	e cause o	f death?
equire:	Completed by	ATRINA	Pus	MILO	son	, 6	four	list.	an I	19800	ragia		1 🗆	Yes 2	□ No 3□	] Prob	ably 4	Unknown
faw re nas be	plet												24a. Wa	opsy	prio	to cor	psy finding	s available f cause of
n: The icate I													per 1 □ Yes	formed?	deat	h? Yes	2 🗆 No	
siciar certif rector	Be	25. Was case refer examiner? 1 ☐ Yes 2 ☐		<u> </u>	spital:	11				DO! Oth	ner:		(Check only		6 ☐ Other (			
g Phy er this eral d	n: T	27. Manner of Deat	th		28a. Date		ry	28b. Time	e of	28c. Inju	ry at		28d. Describe			Specif	<u>v)</u>	
endin sath. or: Aft he fun	atio	1 ☐Natural 2 ☐ Accident	5 Pendir investi	gation	(MOI	mn, Daj	y, rear)	injur	M		Yes 2 □ N	lo						
or Att	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ		28e. Place build	e of Injuding, etc	ry - At ho c. (Specif	ome, farm, y)	street, fact	ory, office		2	28f. Location City or To	(Street ar own, State	nd Number o e)	r Rura	l Route No	ımber,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier	Certifyli															
he Ho in 24 l he Fu ipletely	Medical	(Check only one)	2☐ Medical	Examine	er: On the and mai			tion and/o	r investigat	ion, in my	opinion, death	h occurr	ed at the time	e, date an	d place, and	due to	the cause	∌(s)
Veith veith com	Σ	29b. Signature and	title of certifie	and		_			1	29c. Licen:	se number	30	3	29d. Da	ate signed (N	fonth,	Day, Year)	ZIVIR
0.14		30. Name and add	ess of person	who com	pleted car	ISB OF A	eath (Iton	1 23a) /Tur	ne. Print)	~				34	www Se	-4		
441		April	1 0	HAR	LES_	W	) (	070	N	Cho	vus s	ST	Tor	NOW	M	)		
Sta Registra		31. Date filed (Mon	th, Day, Year)	2008	32.	Registra	ar's Signa	ture	retes									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State	of Ma	ryland		rtment <i>tificate</i>				ental Hy		200	1 0	30:	372
			Registrar  1. Decedent's Name (First, Mid	Idle (ast)			Cei	IIICale	OIL			2. Date of De	Reg. No	KUU	0	3. Time o	of Death
_	Physici		Robert Gottli	,								Month	Da		(ear		OPM
	/Medid Examir		4a. Facility Name (If not institut		number)		Т	4b. City, T	own, or l	Location	of Death	Septen		. County of	50 - 60		
	Examil	ier	Doctor's Comm		,	i		Lanh					P	rince	Geo	orge	
	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. las	st birthday)	If Under 1	Year		r 24 Hrs.	8. Date of Bi				lace (State	or Foreign
- 0	Director		197-05-1230	1 M 2 I	F	88	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D January	19,	1920 F	enns	šý1var	nia
	pu >		Usual Residence of Decedent			10- 0'-	~	-41							140	0d. Inside (	City Limits
	aryla shov	7	10a. State 10b. Coun	,			Town or Loc	ation							'		s 2 No
	he M	ect		ce George	e	Bowi	e	401 71-1	2 - 1 -			1	10 0				
	eath with the Marylan is 23a or 28a-f show	ă	10e. Street and Number					10f. Zip (					Ü	itizen of Wh		•	
	death with the Maryland ms 23a or 28a-f show	Funeral Director	12013 Tweed La		acadont E	ver in U.S.	12 14	207		epanie ()	rigin? (Spe	cify Yes or No		ited			
10	ter deal	Fun	<ol> <li>Marital Status</li> <li>□ Never Married</li> <li>□ Married</li> </ol>	Armed	Forces?		IS. VI	Yes, speci	fy Cubar	n, Mexica	an, Puerto I	Rican, etc.)	]		White, 6		
₹ 036	urs af	by	3 ☐ Widowed 4 ☐ Divorce	If Yes,	Give I	[941 <b>-</b>	1	□Yes 2	X No	Specify	<i>/</i> :			Specify:	Cau	casia	.n
Lerit 21215-0036	2 hot	Completed by	15. Deced	ent's Education			16a. Deced	ent's Usual	Occupa	tion			16b. K	Kind of Busi			
2 2	hin 7 e. an "n	ple	(Specify only high Elementary/Secondary (0-12)	nest grade complete	ed) e (1-4or 5+	-)	(Give k life. D	kind of work OO NOT use	done di retired)	uring mo	st of workir	ng					
212	d wit	5			4-		Milit	ary 0	ffic	er			U.S	S. Ai:	r Fo	rce	
35	e file tal Hy d oth	Be (	17. Father's Name (First, Middl	e, Last)						18. Moth	ner's Name	(First, Middle	, Maider	n Surname)	)		
yla	Men Men arke	ျာ	Aaron M. Gott	lieb						Rose	e Bacl	ıman					
oothlieb」 Ro Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Expressione. once.		19a. Informant's Name/Relation				,	•				I Route Numb		-	, ,	Code)	
多っ什/ieb Baltimore, M	i and Healti		Sylma R. Gott	:Lieb - S	pouse							Maryl		ocation - C		un Ctoto	
	iges nt of l		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation		om State		ce of Dispos netery, crem	-	-						•		
丰丰	it. Pa rtmer rtant		4 □ Donation 5 □ Other			Arlir	ngton N					, 2008		ingto			nia
Sal Sal	Depa Impo any i		21. Signature of Funeral Service	e Loensee	520	71 11	A	Name and			-	ferson 1			-		
$\mathcal{O}_{\blacksquare}$			23a. Part1. Inter the disease,	or complications the		the death	100					r. Ale	-	rıa,	VA Z	Approxima	ate
	Physician		shock, r heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cause o	n each line	eu	Kem									Interval Be Onset and	tween Death
	/Medical Examiner		resulting in death)	Due	to (or as a	conseque	nce of):	,		0			1				
		Į.	Sequentially list conditions,	b. — Due	tu furas a	1 + 7Ze	ore of	rebi	241		Hen	0777	na	35			
	ansit Acted	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	₹	10 (0. 40 4		.,,,,										
Ć,	ificate be executed g physician and s the burial-transit	Exa	resulting in death) Last	c	to (or as a	conseque	nce of):										
68760,	te be ysicia e bur	edical		d.													
689	tifical ng phy as th	edi															
Вох	leath certific attending p for use as	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,		of pregnance 2 🏻 Fetal d		Ectopic pre	ananau				- 1	23d. Date	of delive	ery	
Э.	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pr		time of dea		Other (spe			-			Mont	th	Day	Year
P.O.	at the d by the stach	h.	9 🗆 Unknown														
<u>ග</u>	es the	þ	Part II. Other significant condi	_			ing in the un	derlying ca	use giver	n in Part	I.			use contrib			
oro	requii	Completed		ypen	ens	100						1 🗆	Yes 2	2. <b>⊈</b> 1No 3	B∐ Prob	ably 4	Unknown
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<u>=</u>	The	S										perf 1 ☐ Yes	ormed?	o de	ath? □Yes	2 🗆 No	
Vits	iclan certifi ector,	Be	25. Was case referred to medic examiner?	_			/		****		e of Death	(Check only	one)				
of	Phys this al dir	욘	1 ☐ Yes 2 Ø No 27, Mann of Death		☐ Inpatienate of Injury		R/Outpatient			4 🗆 N		ne 5 Res				y)	
Division of Vital Records,	ding Physiclan: The In. After this certificate hat funeral director, page	Certification:	1 Natural 5 ☐ Pend		fonth, Day,	Year)	8b. Time of Injury	м 20	ic. Injury Work?	es 2.⊑	1	28d. Describe	now inju	iry occurred	1		
<u>.s.</u>	tten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could	I not be	ace of Injur	rv - Athom	e farm stre			63 ZL		28f. Location	(Street a	nd Number	r or Rum	l Route Nu	mher
Š	after after Dire	ertii	4  Homicide deter	mined 200. Fig	ilding, etc.	(Specify)	e, farm, stre	oi, idoloi,	000			City or To	wn, Stat	e)	Or mana	rroute ru	mboi,
	To the Hospital or Attending Physiclan: The law requires that the death certif within 24 hours after death.  Within 24 hours after death.  Within 24 hours after death.  Completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certify	ing Physician: To	the best of	f my knowl	edge, death	occurred a	at the tim	ne, date a	and place.	and due to the	e cause(	s) and man	ner as s	tated.	
	e Ho.	Medical	(Check only 2 ☐ Medica one)	al Examiner: On the	e basis of anner state	examinatio	on and/or inv	estigation,	in my op	inion, de	eath occurr	ed at the time	, date ar	nd place, ar	nd due to	the cause	(s)
	To th Comp		29b. Signature and title of certif	er				29c.	License	number			29d. Da	ate signed	(Month,	Day, Year)	
	*		MANOW	Hal		M	D		10	06	012	20		9/1	2/	08	
	20	ŀ	30. Name and address of perso	n who completed ca	ause of dea	ath (Item 2	3a) (Type, F	Print)	1. 1/10		1 44	6-216	0	1212113	41	0.7	6711
	0		30. Name and address of person A. Waei Hong	ethmo	4	000	mita	nellu	1110	N.C	1 77	-210	(2)	DWIE	2 2		
	Sta Registr	te	31. Date filed (Month, Day, Yea	2002	. Registrar	r's Signatur	re	Me !									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Sept. **Physician** 2008 Emery Grosz 4:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year. 1**X** M 2 □ F 91 058-40-6551 Director 1916 Romania 10, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Function 2002. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Rockville Md Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 6050 California Circle #207 20852 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2X No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cutter Garments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ignatz Grosz Leni Weiss ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6344 Crosswoods Dr. Falls Church, VA 22044 Alexander Grosz - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 9/23/08 Clarksburg, Md 22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan DR. Alexandria, VA 22315 21. Signature of Funeral Service Licenses Part 1 Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Immediate Cause (Final **Physician** Urian Tract disease or condition resulting in death) /Medical Due to (or as a con equence of) **Examiner** Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami ul or Attending Physician: The law requires that the death certificate be executer after death. Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Wogatu 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man er of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: , 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tr certifier 29c. License numbe 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd ATUL ROHATGI 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 23 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ĩ9, Doris Ε. September 2008 Gaither /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Cherrywood Reisterstown <u>Baltimore</u> If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Ye March 03, Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday **Funeral** <sup>Year)</sup> 1924 1 □ M 2 1 F Director 220-12-8281 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It will dical Environment any injury or other traumatic event, It will dical Environment any once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes र् Maryland Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3606 Langrehr Road 21244 United States of America by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 Married Specify: Caucasian 1 □Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker 12 Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Gaither Anna O'Leary ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lucille Scroggins (Friend) 3608 Langrehr Road, Windsor Mill, MD.21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Pk. 09/23/08 4 ☐ Donation 5 ☐ Other (Specify) | Parkville, MD 21234 22. Name and Address of Facilit Oring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, Maryland 21133 Much MOOJJ3 23a Part 1. Enter we disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) 1ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consecuence of resulting in death) Last Due to (or as a consequence of) F FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available Certification: To Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

			autopsy performed? 1 □ Yes 2 25No	prior to completion of cause of death? 1 □ Yes 2 □ No						
25. Was case referred to medical examiner?		26. Place of Death (	Check only one)							
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Home	5 ☐ Residence 6	☐Other (Specify)						
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		Work?	d. Describe how injury	occurred						
3 ☐ Suicide 6 ☐ Could not be determined		actory, office 28f	f. Location (Street and City or Town, State)	Number or Rural Route Number,						
9a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier		29c. License number	29d. Date	signed (Month Day Year)						

Septembe 19,2008

MD

State Registrar

Medical

115 dis Mt 31. Date filed (Month, Day, Year) SEP 2 3 2008

30. Name and address of person who co

Main

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** David W. Geraghty September 16,2008 10:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Medical Center Baltimore City If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**□M 2□F Yrs 54 Oct. 12,1953 Marvland 213-64-8174 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Maryland Baltimore City N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1015 South Linwood Avenue 21224 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2XXXNo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: ð 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Maintenance Man Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Geraghty Marie Lange 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 South Linwood Ave. (Brother) Baltimore, MD 21224 Mr. James Geraghty 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 Removal from State Sacred Ht. of Mary Cem. 9/20/2008 5 ☐ Other (Specify) 4 Donation Baltimore, Maryland 21. Signature of eral Service La e 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophageal Carcer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Inderlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 42 CMUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 20XN0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

**Physician** /Medical Examiner death certificate be executed burial-tran and physician the

Director

r 28a-f show notified at

"natural", or items 23a or 3

the Medical

Hygiene.

Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other transments.

other

within 72 hours after

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division or Vital Records,

the þ signed by page 2 s has certificate l မ this After t Certification:

death. I Director: / hours after thin 24 hours at

2

Hospital or Attending

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₹ No 1/12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Cacritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

MD

D 40854 Sept. 17, 2008

30. Name and address of person who oppopleted cause of death (Item 23a) (Type, Print)

David Riseberg, M.D. 227 St. Paul Place Baltimore, Maryland 21202

31. Date filed (Month, Day, Year) 3 State Registrar

29a. Certifier

(Check only one)

Medical

32. Registrar's Signature

Amend 4b per MD G883 9.25/08 TT State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1- State Amend 10c, 10e, 10f, per FH G884 1067 in Cate To Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 22,2008 Physician 1:15 P M Rosa C. Ho September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Philippines 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min Yrs. 66 Director 136-48-4773 1942 June 16, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at Funeral Director 1 ☐ Yes 2 No Maryland Howard Ellicott City Columbia 10e. Street and Number 10326 Hickory Ridge Rd. Apt 10f. Zip Code 10g. Citizen of What Country? 21044 5330 Dorsey Hall Drive Unit #319 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ◯XNo Specify: Chinese Specify. Completed by 3 Widowed 4 Divorced "natural" Item 27 Is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental lem 27 Is marked of Te So San Ho ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander H. Lim, Nephew 3635 Old Court Road Suite 306 Pikesville, MD 21208 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot Metro Crematory Inc. : 09/23/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Cremation Stellety Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 Homan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition resulting in death) **Physician** reasT ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be execufed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the buriah-transit mpletely filled in by the funeral director, page 2 should be detached for use as the buriah-transit Box 68760, % Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specity) P.0. 9 Unknown 9 Unknown this certificate has been signed by al director, page 2 should be detac' 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes 2 ₹No Certification: To 5 Residence 6 Other (Specity) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral L 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) No Charles St Balto and 2120x 670 6 1. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

SEP 23

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Sur A. Honko	1- For State Registrar	f Maryland / Department of Certificate of		giene Reg. No. 20	08 3037					
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	IKO		2. Date of Death Month Day Year September 9, 2008	3. Time of Death 0527 hrs					
	4a. Facility Name (if not institution, give:		4b. City, Town, or Location of Death	4c. County of De Baltimore C						
Funeral	Greater Baltimore Medical C  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Towson  If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or					
Director		38 <sub>Y</sub>	Months Days Hours Min.	02/28/1970	reign Country) N • J •					
any	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Loc	ation	•	10d. Inside City Limits					
-f show	MD BALTIMOI	RE O PA	RKTON	10g. Citizen of What C	1 Yes 2 No					
ath with the Maryland items 23s or 28s-f show any st be notified at once.	10e. Street and Number  1 LITTLE FALLS	CT.	10f. Zip Code 21120	USA	ountry?					
leath with	11. Marital Status  1 Never Married 2 Married	Armed Forces?	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F		merican Indian, Black, c.					
s after dea		1 Yes 2 No	Yes 2 No specify:	Specify: W	HITE					
"natural",  [Examiner sted by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)		ent's Usual Occupation (Give kind of wo most of working life. DO NOT use retire		ess/Industry					
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/occordary (0 12)		GAGE BANKER	BANKI	NG					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last) NICHOLAS HONKO		18 Mother's Name (	(First, Middle, Maiden Surname) ET KORMAN						
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Typ. NICHOLAS HONKO		ng Address (Street and Number or Ri CRANBORNE CHAS	ural Route Number, City or Town, S E FORT MILL, S	tate, Zip Code) . C . 29708 .					
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and IA Important: If item 27 is m injury or other traumatic	20a. Method of Disposition	20b. Place of Disp	osition (Name of cemetery,	Date 20c. Location - Cit						
Limol Pages ment of tant: 1	4 Donation 5 Other Specify:	GREEN M	OUNT CREMATORY		TO CITY, MD.					
Bally permit Depar Impor	21. Signature of Funeral Service License	22   H	Name and Address of Facility IENRY W. JENKIN 6924 YORK RD M	S & SONS CO. ONKTON, MD. 21	111.					
Physician /Medical	23a. Part i. Enter the disease, or complice failure. List only one cause on each	cations that caused the death. Do not ente	the mode of dying, such as cardiac or	respiratory arrest, shock, or heart	Approximate Interval Between Onset and					
'xaminer	Immediate Cause (Final disease or condition resulting in death)	ue to (or as a consequence of):	tic (oxycodone & 1	ramadol) Intoxi	callon					
Ter	Sequentially list conditions, if any, leading to immediate D	ue to (or as a consequence of):								
red Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):	X							
		AMENDED 23a,P11,27,28	a-f per ME g883 9,	/24/08 TT						
760, cate be execu physician and the burial - tra		23c. If yes, outcome of pregnancy		23d. Date of del						
). Box 687 the death certific by the attending I ched for use as the	23b. Was decedent pregnant in the past 12 months?	D	Fetal death 3Ectopic pregnar  Other (Specify)	ncy Month	Day Year					
the deat by the at ched for	1 Yes 2 No 9 Unknown  Part II. Other significant conditions	Unknown  contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribut	e to the cause of death?					
P.C. res that signed ! be deta	Athorogoleratio	cardiovascular dis		1 Yes 2 No 3	Probably 4 🗹 Unknown					
Records, The law requires ficate has been sig					e autopsy findings available to completion of cause of					
Rec : The lifficate h	25. Was case referred to medical		26.Place of Death (Check of	1 Yes 2 No 1 V	Yes 2 No					
Vital ysician his cert directo		spital: 1 Inpatient 2 ✔ ER/Outpatie	Other		Other:					
n of ding Ph After t funeral	27 Manner of Death	28a. Date of Injury (Month, Day,Year)	1 Vac 2 X No. 1	28d. Describe how injury occurred unk						
Division o spital or Attending tours after death. neral Director: After filled in by the function:	2 Accident Investigation 3 Suicide 6 X Could not be	28e Place of Injury - At home farm, st	:02 am -	28f. Location (Street and Number of or Town, State)	r Rural Route Number, City					
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the ledical Certification	4 Homicide determined	(Specify) residence		Parkton, MD						
To the Ho within 24 To the Fu completed	one) 2 Medical Examiner:	<ul> <li>To the best of my knowledge, death occ on the basis of examination and/or investigend manner stated.</li> </ul>								
F 5F ° E	29b. Signature and title of certifier	20121	29c. License number O.C.M.E.	29d. Date signed September 9,						
	30. Name and address of person who co	mpleted cause of death (Item 23a)	O.O.IVI.L.	Ochtember 9,						
0 4	Tasha Greenberg MD. As	ssistant Medical Examiner 11	1 Penn Street, Baltimore, MD	21201	<u> </u>					
State Registrar										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. state of Maryland Per three of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 19 Day Month 09 2008 Hinton 11:00pM Arriver Jean 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Stella Maris Hospice Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M M A F 64 02 <del>55-</del>1585 06 44 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1∩a State 10h County 1X Yes 2 □ No MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5904 Cross Country Blvd 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2√□No Specify. Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. Do NOT use refired)

Exective Administrator
To The Dean 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of Md Elementary/Secondary (0-12) College (1-4or 5+) School of Medicine 12th grade 4yrs+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Murray George A. Conway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21117 19a. Informant's Name/Relationship (Type. Print) 4601 Embasshy Circle Apt 104, Owings, Mill <u> Willie R. Hinton Jr.-Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/25/08 Woodlawn, Md 21. Signature Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, clock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final COLON CANCER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **K** No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Examiner** burial-transit P.O. Box 68760. attending physician for use as the burial Records, Division of Vital the Hospital or Attending Physician: hours after e Funeral

Examiner Medical

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If them 23 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, in Assistant Exercises must be notified at

Physician

/Medical

Baltimore, Maryland 21215-0036

SEPTEMBER 19,

/Medical

Director

Funeral

Completed

Be

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Physician/Medical Completed Be Certification: To

29a. Certifier

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State Registrar

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. DR. ERNESTINE WRIGHT 31. Date filed (Month, Day, Year)

SEP 23 2008 Registrar's Signature

5

State Registrar DR. ERNESTINE WRIGHT 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year) 32 Registrar's Signature

ORIGINAL

TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

а.ш.

SEPTEMBER 20,

JOSEPHINE HOMA

RICHARD

SEP 2 3 2008

31. Date filed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinant must be notified at Baltimore, Maryland 21215-0036

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Physician/Medical Examiner

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by State Registrar DHMH 17 Rev 1/2001

Decedent's Name (First, Middle, Last)			rtificate of Dea	1111	Re	g. No.	U Q	30300
Betty A. Heck					2. Date of Deat Month Septembe		2ďô′8	3. Time of Death 4:30 AM
. Facility Name (If not institution, give s			4b. City, Town, or Loca	ation of Death		4c. County	of Death	1.50
1115 W. 40th Stree  Social Security Number 6. Sex		rs. last birthday)	Baltimo	ore Inder 24 Hrs.	8. Date of Birth	N/A	9 Rirthr	place (State or Foreign
223–46–9015	71 2 2 2 2 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yrs.		ours Min.	July 2,	Ť937	Virg	jinia
ual Residence of Decedent a. State laryland N/A	10c. (	City, Town or Lo Baltir					1	0d. Inside City Limits 1XX¥es 2 ☐ No
e. Street and Number 1231 Hickory Avenu	ıe		10f. Zip Code 2121	1	11	og. Citizen of V USA	Vhat Cour	ntry?
. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1		Was Decedent of Hispar If Yes, specify Cuban, Mo 1 □Yes ※No Sp	nic Origin? (Spe exican, Puerto ecify:	ecify Yes or No- Rican, etc.)		k, White,	
15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of worki	ing	16b. Kind of Bu	ısiness/1n	dustry
Elementary/Secondary (0-12)	College (1-4or 5+)		tory Worker			Plastic	c Mar	nufacturing
r. Father's Name (First, Middle, Last) Fred Hamm			18.		e (First, Middle, N Fay Hamn		ne)	
9a. Informant's Name/Relationship (Type Thelma Heck Da	pe. Print) aughter	19b. Maili	ng Address (Street and N 1115 W. 40th	lumber or Aura 1 <b>Stree</b>	al Route Number t, Balti	City or Town, More, l	State, Zit Mary	and 21211
a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donatign, 5 ☎ Other (Specify)	emoval from State		osition (Name of matory or other place) wn Cemetery	- 1		20c. Location -	•	
3a. Part 1. East the disease, or complice shock, or heart failure. List only on mediate Cause (Final isease or condition sulting in death)  a dequentially list conditions, any, leading to time distance. Enter Underlying	ne cause on each line.	equence of):						Approximate Interval Between Onset and Death
ause (Disease or injury at initiated events	Due to (or as a conse	equence of):						
ause (Disease or injury at initiated events sulting in death) Last	Due to (or as a consideration of the consideration	nancy etal death 3 [	☐ Ectopic pregnancy ☐ Other (specify)			23d. Dai Mo	te of deliv	ery Day Year
ause (Disease or injury at initiated events sulting in death) Last  FEMALE:  ab. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	3c. If yes, outcome of preg 1  □ Live birth 2 □ Fe 4 □ Pregnant at time o 9  □ Unknown	nancy otal death 3 [ of death 5 [	Other (specify)	Part I.	23e. Did tob	Mo pacco use cont	onth	Day Year he cause of death?
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FEMALE: b. Was decedent pregnant in the past 12 months? 1   Yes   No 9   Unknown   rt II. Other significant conditions co	3c. If yes, outcome of preg 1	pnancy stal death 3 [ of death 5 [ esulting in the u  ER/Outpatiet 28b. Time o Injury	Other (specify)  nderlying cause given in  26.  nt 3 DOA Other: 4 f 28c. Injury at Work? M 1 Yes	Place of Death □ Nursing Ho 2 □ No	24a. Was ar autops perform 1 — Yes an (Check only on the control of the control o	Mo pacco use cont s 2 No pacco use cont s 3 No pacco use cont s 3 No pacco use cont s 4 No pacco use cont s 5 No pacco use cont s 5 No pacco use cont s 5 No pacco use cont s 6 No pacco use cont s 6 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7 No pacco use cont s 7	anth  aribute to t  aribute to t  aribute to t  aribute to t  aribute to to to to to to to to to to to to to	Day Year  he cause of death?  bably 4 Unknown  posy findings available impletion of cause of 2 No

7612 FALLS TOAD BALTIMORY NO 21211

LANSON MS
32. Registrar's Signature

Wanda G.  $H \circ b son \omega \alpha nc$ Baltimore. Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

				Type or Prir							egible.		
		For State Registrar	amend	#18 Per FH	arylan g883	d / De 9 <b>/2</b>	epartment of I 5/08 JH Certificate of	Health and N <i>Death</i>	lental Hy	giene Reg. No2	008	3038	3
Physici	an	1. Decedent's Nam	e (First, Middle, L	ast)					2. Date of De Month	ath Day	Year	3. Time of Dea	
/Medi			G. Hobs						9	15	2008		M C
Examir	ner	,		ive street and number)	_			or Location of Death			ounty of Death		
<i>.</i> -		FRANKLI 5. Social Security N		Sex 17.Aq	Tal ( e (In yrs. I	ente	teat and a second	Sedale	8 Date of Bir		Celtiv 9 Birth	place (State or Fo	reian
Funeral Director		257-94 Usual Residence of	-2272		54	Yr	Months Days	Hours Min.	8. Date of Bin (Month, Did 8 – 8 – 1	954	Cou	ntry)	
/land low		10a. State	10b. County		10c. City	, Town o	r Location					10d. Inside City Li	mits
Aa-f st	cto	MD	Baltim	ore	Ва	ltir	nore					1 □Yes 2 5	₹No
th the	Director	10e. Street and Nu	mber				10f. Zip Code			10g. Citize	n of What Cou	ntry?	
ath wi	[a]	4 Cros	swall C	ourt			21236			USA			
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ity or other traumatic event, Ina Modical Examinat must be nutified at	by Funeral	11. Marital Status 1 □ Never Marr 3 □ Widowed	ied 2☐Married	12. Was Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S	5.	13. Was Decedent of H If Yes, specify Cub 1 □Yes 2 □ No		ecify Yes or No Rican, etc.)		. Race - Amer Black, White, pecify:		
in 72 hour	Completed	(Spec	15. Decedent's E	Education rade completed)		16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	oation during most of work d)	ing	16b. Kind	of Business/Ir	ndustry	
i with	E	Elementary/Seco	ondary (0-12)	College (1-4or 5	i+)		Disable			Dis	sabled		
Id be filed Mental Hyg rked othe tic event,	To Be C	17. Father's Name Unknow		ot)				18. Mother's Name			irname)		
and Nama	-	19a. Informant's N	,			19b. N	failing Address (Street	and Number or Rur	al Route Numb	er, City or T	own, State, Z	p Code)	
and 2 and 2 ealth n 27 i		Kelvin	Hobson	- Husband			Crosswal		, Balt				
Figure 1		20a. Method of Dis		☐ Removal from State			isposition (Name of crematory or other place		Date	20c. Loca	tion - City or T	own, State	
Pag ment ant:			5 ☐ Other (Spec		Ba	yvie	ew Cremat				imore		
permit. Pages 1 and 2 Department of Health of Important: If item 27 is any injury or other tra		21. Signature of	neral Service Lio	isee	_		PA, 2134						om∈
Physician /Medical		23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	ırt failure. List onl (Final on	mplications that caused y one cause on each li a. ACUTE Due to (or as	ne. MYOC	ARD	IAL INEAL		or respiratory a	arrest,		Approximate Interval Between Onset and Deat	n :h
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cate be executed physician and the burial-transit	<u></u>	resulting in death)	Ĺast	Due to (or as	a consequ	ence of):	:						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 I 9 ☐ Unknown	months?	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal	death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		230	d. Date of deli Month	very Day Year	r
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fing F After funer	io ::	27. Manner of Deat 1 ₩ Natural	5 Pending	28a. Date of Inju (Month, Da		28b. Tim Inju	ıry Wor	k?	28d. Describe	how injury o	ccurred		
death death stor: / the i	Certification:	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not		ury - At ho	me farm		Yes 2□No	28f Location	Street and I	Number or Bu	ral Route Number,	
or A after Direc	i#	4 Homicide	determine	d building, et	c. (Specify	nie, iaim	, street, factory, office		City or To	wn, State)	variber or nu	ai noute Number,	
Hospital 4 hours Funeral tely filled	Medical Ce	29a. Certifier (Check only one)		Physician: To the best aminer: On the basis o	f examinat								
o the ithin 2 o the omple	Med	29b. Signature and	title of certifiera	and manner sta	ated.		29c. Licens	se number		29d. Date :	signed (Month	, Day, Year)	
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6		DR Ba Yi		completed cause of d	eath (Item	23a) (1y	pe, Print)	DR 13-1	Tim on.	- im	d 2.1	2.37	
Sta	ite	31. Date filed (Mon	th, Day, Year)	32 Registr	ar's Signal	ure	B COLLEGE	in pac	· in or c	P F L	J. U. C		
Registi		1	SEP 2 3 2	2008 Sur	to So	P. A.	puere 1						

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** SEPT 13, 2008 11:30 P JAMES M. HANEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** JOSEPH RICHEY HOSPICE BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 5, Director 63 SEPT. 1945 212-42-9192 Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 X Yes 2 □ No Directo BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral HOMELESS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Menta item 27 is marked ၉ JAMES R. HANEY VIOLA E. OLSON 19a. Informant's Name/Relationship (Type. POCIAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an DANIELLE F. TURNER/WORKER 21208 3 MILFORD MILL RD., PIKESVILLE, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/17/2008 | HANOVER, MD ARDENT 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Acensee 23a. Parta Enter the disease, 2007-09 EASTERN AVE., BALTIMORE, MD raru enter the disease, complications that caused the shock, or heart failure. Les only one cause on each line ediate Cause (Final ase or condition Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Blad der Immediate Cause (Final **Physician** disease or condition resulting in death) cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): executed and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Day Ye ar Month 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 N6 1 ☐ Yes 2 🗆 No 1 □Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 | Yes 2 | 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Hother (Specify) Certification; To HUSPICE this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier SEptember 14, 2008 00058771 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arleve Res B 878 North Entru d'Freez 31. Date filed (Month, Day, Year) 32. Registrar's Signature Carle March SEP 23 Registrar

9

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 1517 HINES ELVTRA 2 13, 2008 4c. County of Death SEPTEMBER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHEVERLY PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL If Under 24 Hrs. 8. Date of Birth Month, Day Yea 9/20/1916 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Hours WILLISTON, N.C. 1□M 2 F Months 095-26-1529 91 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c, City, Town or Location 10h Count 10a. State 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experience, ust be notified at 1 √Yes 2 □ No Completed by Funeral Director WASHINGTON D.C. 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number UNITED STATES 20019 4407 EADS ST., N.E. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F CARRIE SWEARINGEN ROBERT SWEARINGEN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4407 EADS ST., N.E. WASHINGTON, D.C. 20019 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau TIASIAH HINES/GRANDDAUGHTER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 9/22/08 Brentwood, Md 4 □ Denation 5 □ Other (Specify) 22. Name and Address of Facility CAP ITOL MORTUARY 21. Sign dure of Funeral Servi e Lice 1425 MARYLAND AVE., N.E. WASHINGTON, D.C.20002 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Jist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAL ARRTHYMIA FATAL Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🕅 No 5 Other (specify) Pregnant at time of death signed by the a o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy page perform 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending Volume 124 hours after town...

To the Funeral Director. Aft 1 ☐ Yes Investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0066417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE CHEVERLY 3001 MA BELPORTO. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

SEP 2 3 2008

			1- For Hagistrar #22 Per FH G8	ate of Maryland / 383 9/23/08 Ji	Depa H <i>Cer</i>	irtment <i>tificate</i>	of Health an <i>of Death</i>	d Menta	al Hygiene Reg. No	Z U U Ö -	30384
E	Physici	ian	Decedent's Name (First, Middle, Last)     LEE INGRAM					Mo			3. Time of Death
1	/Medi	cal	4a. Facility Name (If not institution, give street	t and number)		4h Ciby T	own, or Location of C			9, 2008 County of Deatl	2:00 A <sup>M</sup>
, į	Examir	ner	ANNAPOLIS REHAB & NU			ANNAP		76411		ANNE ARI	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last t		II Under 1	Year If Under 24	Hrs. 8. Dat	te of Birth onth, Day, Year,		nplace (State or Foreign untry)
	Director		245-46-1334 15xM	2LF 74	1 Yrs.	IVIOLITIS	Days Hours		IL 27,	1934	
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Mary	į	MD PRINCE GEORG	GE'S CAPITO	OL HE	EIGHTS					1 X Yes 2 ☐ No
	or 284	Director	10e. Street and Number	. T.Z		10f. Zip C	ode		10g. Ci	tizen of What Co	untry?
	ath w	ra	4153 SOUTHERN AVENUE		1.0.1		. 148	0.404		ITED STA	
320	172 hours after death with the Maryland "netural", or items 23a or 28a-f ehow idigal Examiner must be notified at	by Funeral	1 Never Married 2 Married 1	Vas Decedent Ever in U.S. Imed Forces?  Yes 2 No Yes, Give 2 Year or Dates:		Vas Decede Yes, specif	nt ol Hispanic Origin y Cuban, Mexican, P No <i>Specify:</i>	Puerto Rican,	etc.)	14. Race - Ame Black, White Specify: BI	
5-0036	72 hor	eted	15. Decedent's Education (Specify only highest grade con		a. Deced	lent's Usual	Occupation done during most of	f working	16b. k	(ind of Business/	Industry
2	within 72 ene. than "nat	Completed		college (1-4or 5+)	life. C	OO NOT use	retired)			ייי איז די די די די די	
N	filed v Hygie ither t		17. Father's Name (First, Middle, Last)				LABOR 18. Mother's		Middle, Maider	PRIVATE	
land	id be lentai ked o	To Be	NATHAN STANDBACK				SADD	IE ING	RAM		
Mary	d 2 should th and Mer 7 ie marke traumatic	-	19a. Informant's Name/Relationship (Type, F			_	Street and Number o		Number, City	or Town, State, 2	(ip Code)
	s 1 and 2 f Health item 27 l		BETTY RHONES/DAUGHT				ERN AVENU				rs. MD.20743
altimore,	80=5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove	val from State ceme	tery, crem	sition (Name natory or oth	er place)	Date		ocation - City or	
			4 ∑Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service (Licensee f)	CHES			MATORY   9 Address of Facility	/15/08		LTSVILLI	E, MD
ğ	permit. Departrimports any inju		Mayor AH	Man Itall	212		Maryland				DC 20002
			23a. Part1. Enter the disease, or complication shock, or heart failure. Lift doly one call immediate Cause (Final	ns that caused the death. Duse on each line.	o fit ente	er the mode	of dying, such as ca	rdiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical Examiner physician and physician and physician and physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are ph	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence)	e ol):						Unhamin	
C. Box c	thet the death certified by the attending properties as	Physician/Me	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal dea □ Pregnant at time ol death □ Unknown		Ectopic pred Other (spec				23d. Date ol deli Month	ivery Day Year
as, F	8 E 6	þ	Part II. Other significant conditions contribu	ting to death but not resulting	in the ur	nderlying cau	use given in Part I.	23	3e. Did tobacco	_	the cause of death?
Hecords	0 = 0	Completed						_	a. Was an autopsy performed	death?	ntopsy findings available completion of cause of
VITAI	vician: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of	Death (Chec	Yes 2 No ck only one)	0 1 ☐ Yes	2 140
> 5	Physician: rthis certific rat director,	ျ	examiner?	1 Inpatient 2 EHV	Outpatien			ng Home 5	Residence	6 ☐Other (Spec	city)
	ding Phys	lon:	1 Natural 5 ☐ Pending	Ba. Date of Injury 28b (Month, Day Year)	. Time of Injury		Work?		escribe how inju	iry occurred	
DIVISION	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	Certification:	Accident investigation  3 Suicide 6 Could not be determined	Be. Place of Injury - At home, building, etc. (Specify)	larm, stre	M eet, factory,	1 Yes 2 No	281. Lo	cation (Street a ty or Town, Stat		ıral Route Number,
	ne Hospite n 24 hours ne Funeral	Medical C	(Check only 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a and manner stated.	lge, death and/or inv	estigation, in	the time, date and a n my opinion, death	place, and dis occurred at the	e to the cause(s	t) and manner ac id place, and due	stateu. to the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier				License number			ate signed (Monti	
	0		Kita Dhawa	n, MD		I	00 625	534	109	13/20	208
	7		30. Name and address of person who complete	ited cause of death (Item 23a		Print)	1 81200	BALC	TAN	INTA PALLO	MARYLAND
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		× 7 (1)		U 1V	F1 1130	איויייייי >	( and distant
	Registr		SEP 2.3 2008 A	10 al. 1. 1	Source	200					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 7-05A M JOHNSON SEP 1 2008 TERRILEE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death renesis Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 6. Sex Social Security Number Months Days Hours Min. 1 M 2 T 214-64-4065 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location altimore 1/ Yes 2 No W 10e. Street and Number 10g. Citizen of What Country? 3938 Kimble 21218 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Amarried 1 ☐ Yes 2 Z No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1340 Carsiye 17. Father's Name (First, Middle, Last) Middleton Harriett Sidner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3928 Kimble Ad Baltimore, MD 21218 Jerry Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodkun Cenetery 9.23-2008 Baltimore MD 22. Name and Address of acility Vaughn C. Oreene Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vaughn C. Sheene 4905 York Rd Baltimo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MID 2612 Approximate Interval Between Onset and Death Immediate Cause (Final SCLEROSIS MULTIPLE disease or condition resulting in death) Due to (or as a consequence of): SEIZURE DIJORDER Sequentially list conditions, if any leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 Tyes 2 No 2 DAccident

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriet-transit manner.

Be

**Physician** 

/Medical

Examiner

**Funeral Director** 

Completed by

Be

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Funerai

Director

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exactions count to excite all

Health and Mental Hygiene. em 27 is marked other than

permit. Pages 1
Department of Hi
Important: If iten
any injury or oth

**Physician** 

/Medical

Examiner

Physician/Medical Completed by Certification: To

Examiner

Medical

Registrar

Shakunmale 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

graple

2008

Sopre MO

6 ☐ Could not be

determined

23

MP gistrar's Signature

Sentrajo Rd Suite 110 Columbia 9650

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

00053150 13 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 2 0 08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20,2008 Physician September 5:00 am <sup>M</sup> William John Jerome /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Future Care - North Point Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 10,1930 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 X M 2 □ F 217-26-7693 78 Ohio Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f shov 1 ☐ Yes 2 No Maryland baltimore Directo Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 2905 Dunbrin Road Apt A. 21222 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by Specify: White 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Item Sonce. Elementary/Secondary (0-12) College (1-4or 5+) 10 years Painter Shipyard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William John Jerome Sr. Mable C. Pitcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Jerome wife 2905 Dunbrin Road Apt. A, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 26, 2008 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease, of complications that caused the death. Danot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1 Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE OBSTRUCTIVE **Physician** HRONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi): law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 □Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation death. reral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined l or A 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie and manner stated. 29b. 29d. Date signed (Month, Day, Year) Signature (EPTEMBER 22, 2008 D0060560 reled cause of death (Item 23a) (Type, Print) BACK RIVER NEUR RD. #109, BALTIMORE, MA-2124 201, 31. Date filed (Month, Day, Year) SEP 2 3 Signature 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death

			for State Registrar	State of Marylar		rtificate of			g. No.	8 30387
	Physicia	an	1. Decedent's Name (First, Middle, Las Christina	Alice		Joyner		2. Date of Death Month September	er 20, 200	3. Time of Death 8 16:14 M
-	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	ith
and the			3432 Liberty Parky			Dunda l	.k   If Under 24 Hrs.	0.01. (0.1	Baltimor	
H	Funeral Director		214-70-2793	ex		Months Days	Hours Min.	8. Date of Birth (Month, Day September 2	1958 Mar	rthplace (State or Foreign ountry) yland
	and wo		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Baltimor	re li	Dundall	ζ.				1 □Yes 2 No
	with the 3a or 28a 1 be roll	I Direc	10e. Street and Number 3432 Liberty Parkv	<i>i</i> ay		10f. Zip Code 21222	2	10	g. Citizen of What C USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examinar meat be redified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		∐ Was Decedent of H fYes, specify Cuba l □Yes 2【XNo	lispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
2-0	72 ho "natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done	oation during most of world)	king 1	6b. Kind of Business	/Industry
121	within iene. than	dmo	Elementary/Secondary (0-12) 12 years	College (1-4or 5+) 4 years		ousewife	a)		Own Home	
Baltimore, Maryland 21215-0036	d be filed ental Hyg ced other c event, I	Be	17. Father's Name (First, Middle, Last) Joseph Williams	7 0000			18. Mother's Nam	ne (First, Middle, M t Nolan	aiden Surname)	
ary	should and Me Is mark aumath	2	19a. Informant's Name/Relationship (7		1	•			City or Town, State,	
<u>ر</u>	and 2 Health Im 27 I		Luther E. Joyner	Husband			Parkway, 1			21222
more	Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State Day	riace of Dispo cemetery, cren View Ci	sition (Name of natory or other place rematory	Septe	SUDET	Oc. Location - City or Baltimore,	
Balt	permit. Departi Importa any inji		21. Signatur Funeral Service Licen		Ç.	Name and Addre	ss of Facility uneral He ers Point	ome Of Du Road, Du	ındalk,P.A ındalk,Md.	*21222
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	- 10	tedqu	er the mode of dying	ng, such as cardiac	or respiratory arre	est.	Approximate Interval Between Onset and Death
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseq	uerice of).				135	
68760,	rificate be executed ig physician and as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):					
O. Box	ath cer attendin for use	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregni 1  Live birth 2 Fete 4  Pregnant at time of o	ıl death 3 [	Ectopic pregnand Other (specify)	у		23d. Date of de Month	olivery Day Year
rds, P.	w requires that the de been signed by the should be detached		Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			o the cause of death?
al Records,	Physician: The law rer r this certificate has bee ral director, page 2 sho	Completed						24a. Was an autopsy perform 1 □ Yes 2	/ prior to	
Vital	sician certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:		• a TI DOA Oth	or:	th (Check only one	:	
on of	ine ine	tion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Mooth, Day, Year)	28b. Time of Injury	28c. Injui Wor	y at	/	nce 6 ☐ Other (Sp. w injury occurred S	(A) (A)
Division of	ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A pletely filled in by the fu	Certification: To	2 Accident Investigation Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	y) 1		163 2 1	f. Location (Str. City or Town,	eet and Number or F. State) 343.Z.	Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direction completely filled in bigging the complete of the property	Medical (		ysician: To the best of my kno Iner: On the basis of examina and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	Don 1		29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
	4	9	en Name and address of person who o	ompleted cause of death (Iter	n 23h) (Type,	Print) H:11	CT. L. L	hom: 110	141 Zr	343
			· 100011- 1 111014				-1 001	-// 11		

State Registrar

State 31. Date filed (Month, Day, Year)

2 2008

32 Registrar's Signature

both

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** September 19 acksor 10:30 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FORD leigh BALTIMOR (
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 X M 2 □ F 05/28/1924 84 Director 214-12-9389 Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show Yes 2 No Directo Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or 2 Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 4111 Fordleigh Ln. 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1▼Yes 2 □ No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 **Black** ö 1 □Yes 2 No Specify: þ other traumatic event, the Medical Exa-3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 is marked of ၉ George Jackson Florence Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorthy B. Jackson / Wife 4111 Fordleigh Lane, Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of F Important: If ite any injury or of once. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 09/24/2008 Garrison Forest Ceme. Owings Mills, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H P.A. 21. Structure of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rectal cavanana **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Exami the deeth certificate be executed Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 214 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director, After t Certification: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Dimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOS7436 who completed cause of death (Item 23a) (Type, Print) 22 5. (Vere A Bartina mo 21201

Registrar

31. Date filed (Month, Day, Year) SFP 2 3 2008

32. Registrar's Signature

Veryber

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the Maryland 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the involced Examinar must be notified at Director Felton DE 10e. Street and Number 10f. Zip Code death with 19943 Funeral 408 South Erin Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Hair Dresser 09 n/a 17. Father's Name (First, Middle, Last) Be h and Mental h and 2 should be Betty Helen ဥ Joseph Preston 19a. Informant's Name/Relationship (Type. Print) of Health item 27 i 408 South Erin Avenue, Felton, DE Bonnie Stronsky/Sister SEPTEMBER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ō permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal; 4 ☐ Donation 5 ☐ Other (Specify) 9/18/08 Atlantic Crematory 21. Signature of Funeral Service Light 22. Name and Address of Facility Trader Funeral Home Timothy Harman 12 Lotus Street, Dover, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Physician **HUMAN IMMUNODEFICIENCY VIRUS** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is a sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) physician Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1∐Yes 2**X**No P.O. ed by the detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 24a. Was an page 2 s autopsy performed After this certificate BRENDA 1 ☐ Yes 2 X No of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Hospital or Attending Division 1 X Natural 5 Pending investigation ours after death.

neral Director: A

filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier To the Hosp within 24 ho To the Fune completely f one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. egistrar's Signature 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 13,2008 12:02 A M Sue Jones Brenda 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Timonium Stella Maris 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours 1 □ M 2 🗓 F Months July 17, 1957 Maryland 215-68-3171 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Cosmetology 18. Mother's Name (First, Middle, Maiden Surname) Lou Plunkett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Glen Burnie, Maryland Approximate Interval Between 23d. Date of delivery Year Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day September 18, **Physician** Rose Marie Johnson 2008 12:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Ridgeway Manor Nursing Home
5. Social Security Number 6. Sex 7. Age (In yrs Catonsville
If Under 1 Year | If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🖼 F 212-28-4688 78 Director March 26, 1930 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 🔀 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Rollingfield Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ♣No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may injury or other traumatic event, the McCicol Examinand and. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No \$ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Wrapper Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gordon L. Dreisch Florence Beavin 2 19a. Informant's Name/Relationship (Type. Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5058 Summer Day Lane; Columbia, MD 21044 Mary Patricia Lubbehusen 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 9/22/2008 Timonium, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lite 1630 Edmondson Avenue; Catonsville, 02/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 😼 Physician: 25. Was case referred to medical examiner? Be 26. Place Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) 1009 31. Date filed (Month, Day, 32. Registrar's Signature State 23 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend State of Maryland / Department of Health and Mental Hygiene Amend ITEM#7,8perFH (888),1/23/09,WS

AMEND ITEM#7,8perFH (888),1/23/09,WS

Reg. No. 0 8 Reg. No. UU 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day September 18, 2008 11:10 am Kathryn K. Kostinsky 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Catonsville
If Under 1 Year | If Under 24 Hrs. Baltimore Charlestown Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yelr 924 Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 🔀 F 218-14-0797 84 - 83 Yrs. 11/03/<del>1923</del> Baltimore, MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Baltimore 1 ☐ Yes 2 ☐ No Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 715 Maiden Choice Lane 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Accountant Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry Kirkwood Katherine Staplehorse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen L. Cohen (Daughter) 125 Carlyle Circle, Palm Harbor, Florida 34683 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Meadowridge Memorial 09/22/2008 Elkridge, Maryland ' 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hubbard Funeral Home, Inc. Made T. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only account on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heroschot.c (OLANO Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Sath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. 29a. Certifier

requires that the death certificate be executed Box 68760 o Records, P. Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

**Physician** 

/Medical

Examiner

10a. State

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**Funeral** 

Director

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other

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permit. Page Department o Important: If any injury or once.

**Physician** /Medical

Examiner

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Physician/Medical

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Completed

Certification:

29b. Signature and title of certifier

30. Name and address of per-

~ 31. Date filed (Month, Day, Year)

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Pages 1

hours after

Maryland 21215-0036

Baltimore,

State

DHMH 17 Rev 1/2001

Registrar

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32. Registrar's Signature

2008

			1 - For State Registrar	State of Ma	aryland		artment o			Mental Hy	giene	_ U U	8	303	92
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	ams ams	ine	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	5. 13.	Was Deceden If Yes, specify	t of Hispan Cuban, M	nic Origin? (S exican, Puert	pecify Yes or N o Rican, etc.)	0-	<ol> <li>Race - Black,</li> </ol>	America White, e		
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	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):									
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200	death certificate e attending physi d for use as the	Physician/Med	IF FEMALE:												
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	Physician: this certificatal director,	To	examiner? 1 Yes 2 No	Hospital:	ent 2 E	R/Outpatier	nt 3□ DOA	Other: 4	Nursing H	lome 5 Res	idence	6 Other	(Specify)		
0	g Ph	ou:	27. Manney of Death	28a. Date of Inju (Month, Da	ry Yearl	28b. Time o	f 28c.	Injury at Work?		28d. Describe					
0	ath. r: At	atlo	1		, , , , ,	пцату	М	1 Yes	2 🗌 No						
UIVISION	Atta	E E	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ury - At hor	ne, farm, str	eet, factory, o	ffice		28f. Location	(Street an	d Number	or Rural	Route Numb	er,
5	s aft al Di	Certificati		January, Ja	o. (=poony)					3.9	,	,			
	To the Hospital or Attanding Physician: To the Funaral Birector: After this certific completely filled in by the funeral director,	cal	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis of	of my know	riedge, deat	h occurred at t	he time, da	ate and place	, and due to the	cause(s)	and mann	ner as sta	ted.	
	in 24 he Fi he Fi plete	edical	one)	and manner sta	ated.	on and/or in	vestigation, in				, uate and	piace, an	u uue to l	uie cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	Ma				icense nun	mber			e signed (			
	<		· Choelo	, ,				> 50	0012		50	pt	22	200	18
	1		30. Name and address of person who		-				14.	tmente		1	,		
_			6 INU CHACK	291	Stor	er /	heme		Wel	tmente	\ /	ND S	1157		
	Sta Registr		31. Date filed (Month, Day, Year)	327 Registra	ar's Signati	ire /	68								
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		1	For State Registrar		·yiaiiai	Cer	tificate of	Death			Reg. No.			
Phys	ician		. Decedent's Name (First, Middle, Las		2. Date of D Month				eath 3. Tim					
	dical		Barbara Jean			7				eptemb	er 18	2008		£ W
Exar	niner		a. Facility Name (If not institution, giv Union Memorial	Hospital				ltimo	re			N/A		
Funer Direct			. Social Security Number 6. S 217–34–9066 1	ex	(In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under Hours	Min. J	Date of Bir (Month, Da une 2	th ly, Year) , 193	Cou	place (State of intry) Virgi	
yland	ή.	1	0a. State 10b. County		10c. City, Tov	wn or Loc	cation						10d. Inside Ci	ty Limits
e Mar Ba-f s	Director		Maryland N/A				Baltimore					XXYes 2 □ No		
th with th			10e. Street and Number 4123 Falls Road			10f. Zip Code <b>21211</b>					10g. Citizen of What Country?  USA			
er dea Items	Finanzi	1	1. Marital Status	12. Was Decedent Ev Armed Forces?		13. V	Vas Decedent of I f Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Speci n, Puerto Ric	fy Yes or No can, etc.)	-	<ol> <li>Race - Amer Black, White,</li> </ol>		
0036 ours afte ural", or i LEvamil	34	5	1 Never Married 2 Married  3 Widowed 4 Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1	∐Yes <b>X</b> ZNo	Specify.					ite	
15- n 72 h "nati	atal		15. Decedent's Ed (Specify only highest gra	ucation de completed)	16	a. Deced (Give I	lent's Usual Occu  kind of work done DO NOT use retire	pation during mos	st of working		16b. Kir	nd of Business/Ir	idustry	
212   withii giene.	Completed	5	Elementary/Secondary (0-12)	College (1-4or 5+	)		nemaker	<i>u</i> )				Own Ho	me	
Maryland 21215-0036 ad 2 should be filed within 72 hours after death with the Maryland thth and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at	To Be C	מ   1	7. Father's Name (First, Middle, Last) John Cameron					18. Moth	er's Name <i>(F</i> <b>Laur</b>	First, Middle,				
lary 2 shou and h is ma	53		19a. Informant's Name/Relationship (	Type. Print)	19	b. Mailin	g Address (Street	and Numb	er or Rural F	Route Numb	er, City o	r Town, State, Zi	p Code)	
Te, M 1 and 2 Health Tem 27 i		-		Daughter			23 Falls	Roac						
Pages Pages nent of unt: If it		2	0a. Method of Disposition  1 ☐ Burial 2 XCremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specifi		cemet	ery, cřem ntic	sition (Name of natory or other pla Cremato	ry 9		800	Glen	cation - City or T Burnie	, Mary	
Balti permit. Departr Importa	once.	2	21. Signatur of Fineral Service Licer	3. Hens		<sup>22</sup> 13	Name and Address Surgee-He 1631 Fall	ess of Facili 2005–5 S Roa	eitz l	Funera	l Ho	me, Inc	. 21211	I
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that caused to	he death. Do							ar y rang	Approximate Interval Bet	e ween
Physicia		- 1 -	Immediate Cause (Final disease or condition	Chronic C		tive	Pulmon	ary	Dise	ase.			Onset and I	Death
/Medic	_		resulting in death)	Due to (or as a	,	,	6 11	4					1	
	■.	5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								wn			
ansit Adde	Examiner	Ç	f any, leading to immediate sause. Enter Underlying Cause (Disease or injury hat initiated events	-	551.054407.05	J 0.7.								
cate be executed physician and the burial-transit			esulting in death) Last	Due to (or as a	consequence	e of):								
68760, ificate be expression appropriate to the purial to the burial to	Medical	3		d										
Box sath cert attending for use a	Physician/Me		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 0 4 □ Pregnant at time of de 9 □ Unknown				death 3 🗌 Ectopic pregnancy				23d. Date of delivery Month Day Year			
cords, P.O. w requires that the destance signed by the should be detached.									obacco u	co use contribute to the cause of death?				
ords equires en sig	ed by	3 -					1[				Yes 2 No 3 Probably 4™ Unknown			
<b>Hecords,</b> he law requires the has been signer ge 2 should be d	Completed	-								24a. Was		24b. Were aut	opsy findings	available
VITAL RE ician: The lav certificate has ector, page 2:	Con									perfo	rmed? 2 ⊠No	death? 1 □ Yes		
VITAI Sician: Ti certificate rector, pa	B		25. Was case referred to medical examiner?	Hospital:			_ Oth		e of Death (					
Of Phys er this eral di	12	2	1 ☐ Yes 2 ☑No 7. Manner of Death	1 ☑ Inpatien 28a. Date of Injury	t 2 ER/C	Outpatien Time of	1 3 DOA	4 🗆 🗤		5 ☐ Resid. Describe		Other (Spec	ify) (	
nding ath. r: Afte	ation		1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,	Year)	Injury	28c. Inju Wor M 1	kí? ]Yes 2□			,,	,		
DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification: To		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At hom building, etc. (Specify)			ne, farm, street, factory, office  28f. Location City or To			f. Location (; City or To	(Street and Number or Rural Route Number, own, State)				
e Hospiti 124 hours e Funera letely fille	Medical (		29a. Certifier  (Chack only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To th Vithir To th	Me	2	29b. Signature and title of certifier			29c. License number 29				29d. Date	9d. Date signed (Month, Day, Year)			
			Raushan.				AT 2438946 Sep				Sept	otember 18, 2008		
7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ISHRAQUE SHAWON, MD. UNION MEMORIAL HOSPITAL, MD.													
Regi	State													
DHMH 17 Rev			SEP 2 3 2008	January 1	J. 1	M. Africa	y		-					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 18, 2008 4:00 P.M Gebrevesus Kidane 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 114 Clarendon Avenue Pikesville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 28, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months Days Hours Min. 1 M M 2 □ F Eritrea 62 214-41-7014 Usual Residence of Decedent 10a State 10b. County 10c City Town or Location 10d Inside City Limits Maryland Baltimore Pikesville 1 ☐ Yes 2 M No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Eritrea 114 Clarendon Avenue 21208 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Epidemiologist** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kidane Brahi Bir-Siela Teshanes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Clarendon Avenue Pikesville, Maryland 21208 Haney Gebreyesus/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9/20/08 Druid Ridge Cemetery Pikesville Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Maryland 21214 pristin X 5305 Harford Rd. Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEPATIC ENCEMHALOFATHY disease or condition resulting in death) Due to (or as a consequence of): CARCINOM TOCELLULAR YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Be Completed

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Examiner

Physician/Medical

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Certification: To

3 Suicide

29a, Certifier (Check only one)

4 Homicide

d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event, the Med 90se.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

29b. Signature and the of certifier

6 Could not be determined

MOTPHO

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

SEPTEMBER 19, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

401 N. Broadway Baltimore Maryland 21231 Dr. Timothy Barns

31. Date filed (Month, Day, Year) 23 32 Registrar's Signature

State

Registrar

08-0		overi.	Please Type or Print in Black Indelible Ink. Ens			ble.		
Emo	ry Lamont L		State of Maryland / Department of Health a  1-For State Certificate of Death  Registrar	and Mental Hy	giene Reg.	200	8 3039	
Bioo	Physicia lical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Death  Month  September		3. Time of Death 0610 hrs	
Wied	iicai Exami	ner	THINKY L. LEWIS	n, or Location of Death	September	15, 2008 4c. County of Death	00101115	
			1730 N. Fulton Avenue Baltimor			NI	A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1  214-02-4505  Usual Residence of Decedent  Funder 1  Age (In yrs. last birthday)  Months	Year If Under 24Hrs.  Days Hours Min.	8. Date of Birth	1	ntry Mary land	
	D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show any natic event, the Medical Examiner must be notified at once.	al Director	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 No	
			M) Baltimore Kandallsto	ode .	10g	. Citizen of What Coun		
			10002 1111013740000	21133		USA		
	eath wi items ust be	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Co	of Hispanic Origin? ( Spe Cuban, Mexican, Puerto I		14. Race - Americ White, etc.	an Indian, Black,	
	after d al", or iner m	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 ✔	No specify:		Specify: BIC	ack	
	72 hours n "natur al Exami	Completed I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occurrence during most of working	g life. DO NOT use retir		6b. Kind of Business/Ir	ndustry	
	5-0036 iled within 7 Hygiene. I other than the Medica	ошо	10th House K	eeper 18.Mother's Name	(First Middle Ma	Mainta	nce_	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner mi	To Be C	Spencer Boyer	Shelia	Lewis		7in Code	
			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Special Lewis-Drake - 1902 Alle	ensward	Randai	er, city or rown, state, 15-town, Mi	21133	
			20a. Method of Disposition  1	of cemetery,	Date	20c. Location - City or	Town, State	
			4 Donation 5 Other Specify: MT. Zion	9/	20/08	Baltimae,	MD	
			21. Signature of Funeral Service Licensee 22. Name and Add	iberty Ha	ints Au	4. Ralto	MD 21207	
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of defailure. List only one cause on each line.	lying, such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and	
PAN.	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound of Head  Due to (or as a consequence of):				Death	
	e executed cian and rial - transit		Sequentially list conditions, b					
			if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated					
/			events resulting in death) Last Due to (or as a consequence of):					
V		dical	UNPENDED AMENDED					
	68760, certificate bo nding physic se as the bur	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ncv	23d. Date of delivery	yay Year	
	Box 68 c death certil the attending ed for use as	Completed by Physician/Medical	past 12 months?  1		into y	Nichar B	ay roan	
	P.O. Es that the caned by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying car	iuse given in Part I.		acco use contribute to		
	ds, lequires				24a. Was ar	24b. Were au	topsy findings available	
	Recor The law cate has I page 2 sh				autopsy perform 1 ✓ Yes 2	ned? death?	ompletion of cause of	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executivithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Be	25. Was case referred to medical examiner? Hospital:   Inserting to 2   ED/Outpatient 2   DOA	Place of Death (Check of Other)		esidence 6 🗸 Other	Scene	
		on: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c	c. Injury at Work?		w injury occurred	Oddie	
		Certification:	2 Accident Investigation Sep 15, 2008 0559 hrs 28e Place of Injury - At home farm street factory of	ffice building, etc.	28f. Location (St	reet and Number or Ru	ral Route Number, City	
	Div pital or ours aft eral Di filled ir	Sertii	4 V Homicide determined (Specify) Rowhouse		or Town, State) 1730 N. Fulton Avenue, Baltimore, MD			
	o the Hos thin 24 ha the Fuu mpletely	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my op and manner stated.					
	7. ¥ 7. 8	Me	29b. Schappre and title of certifier 29c. Li	icense number		29d. Date signed (Mor		
			1 Colonema	D.C.M.E.	September 15, 2008			
	1		Newfme and address of person who completed cause of death (Item 23a)     Laron Locke MD. Assistant Medical Examiner 111 Penn Street, B	Baltimore, MD 212	01			
	Si Regis	tate trar	A 0 0 2000 Wta					

DHMH 17 Rev 1/2001 OCME 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** September Littles 710 PM Robert George 17,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) Months 214-12-1859 88 Director Φ7 SC 20 Usual Residence of Decedent 10a State 10h County 10c City Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore 1XYes 2 No Director MD NΑ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or U.S.A. 21216 Funeral 1730 Moreland Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Evanning once. Black, White, etc 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 11th grade College (1-4or 5+) Naval Academy Office Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Addie Coleman Jacob Littles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 723 Cooks Lane, Baltimore, Md Sheryl Hamlett-Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 9/23/08 Owings Mills, Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLETORIC Cerdiovercular Discone Unlonge /Medical Due to (or as a consequence of): Examiner End Stage real D2 Sequentially list conditions Dualto (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans 4moHoma Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **12** No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 NO 1 Tes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, been signed by the should be detached certificate has lirector, page 2 s within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, the

Maryland

the

death with

Baltimore, Maryland 21215-0036

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9 31. Date filed (Month, Day, State Registrar

aluje Ma 1600 West 32. Registrar's Signature

and manner stated.

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

2002000

29d. Date signed (Month. Day, Year)

Mr Royal Acce Balt NO 21217

September 17,2008

DHMH 17 Rev 1/200

08-07090 Kenneth Lewis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 30398 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day Y September 17, 2008 Kenneth Mark Lewis 0155 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** 3232 Keswick Road 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** oreign Country) 215-70-4253 Months Days Hours Min Director 45 Nov 16, 1962 1**XX**M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County III 10a. State 1 XXes 2 No MD N/A Baltimore or items 23a or 28a-f show must be notified at once. with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 3232 Keswick Road 21211 U.S.A. 14. Race - American Indian, Black, Funeral Was Deces:
Armed Forces?
XX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or item or other traumatic event, the Medical Examiner must b XXX Never Married 2 Married White If Yes. Give Yea Yes 2XX No specify. Specify 3 Widowed Divorced 4 ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Bay Contractor Construction 10th 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Kenneth F. Lewis Lois Waugh Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 3232 Keswick Road Balto, MD 21211 Lois Lewis (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition timore, Burial 2 XX remation 3 Removal from State Atlantic crematory 9/19/08 Glen Burnie, MD Baltimo permit. Page: Department o Important: linjury or oth Donation 5 Other Specify 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 making of I 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Splenomegaly with rupture Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical 23a,PII,27,perME, G884 10/29/08 TT X UNPENDED physician the burial -Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Day Year 3 Ectopic pregnancy Month Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. \$ Yes 2 No 3 Probably 4 ✔ Unknown Human immunodeficiency virus syndrome Completed s been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has b death? performed? page ✓ Yes 2 ✓ Yes 2 No certificate Fo the Hospital or Attending Physician; 26.Place of Death (Check only one) this certifial director, 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other<sub>4</sub> Residence 6 🗸 Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 🗸 Yes ۵ No After the 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1X Natural Yes 2 No Pending 24 hours after death To the Funeral Director: completely filled in by the Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 17, 2008 1 Sh O.C.M.E. pand 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Mar		partment of F		•	_	
			1 - For State Registrar		-	ertificate of			a. No 2008	30399
			Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
-	Physici /Medic		SAMUEL	M		LIPNICK		Month Sep.	Day Year	202 W
٤	Examin		4a. Facility Name (If not institution,	,		4b. City, Town, o	r Location of Death		4c. County of Death	ew.
-			JEWISH CONVALE				TIMORE		BALTIMO	
	Funeral		· ·	1 DM 2 DE	(In yrs. last birthda)  /. Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		218-16-0886 Usual Residence of Decedent	XX" 2 8	4 113.			JAN.11,	1924	_MD
	/land		10a. State 10b. County	-	10c. City, Town or I	Location				10d. Inside City Limits
	Man	ģ	MD N/A	1	BALTIN	10RE				17 Yes 2 No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	23a c	alD	3021 FALLSTAFF	ROAD #301		212	209		USA	
	eap L	iner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13	. Was Decedent of H	lispanic Origin? (Sp an. Mexican, Puerto	ecfy Yes or No-	14. Race - Amer Black, White	
36	or It	by Fu	1 ☐ Never Married Married	#11410s, Give		1 ☐ Yes XXNo	Specify:	,	Specify:	WHITE
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12	withi Bne.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	CHEN	MICAL ENGI	NEER		EDERAL GOV	ERNMENT
ğ	Hyg other	Be C	17. Father's Name (First, Middle, La	ist)			18. Mother's Nam	e (First, Middle, M	faiden Sumame)	
<u>a</u>	Aenta Aenta Itc e	To B	HARRY L	IPNICK			TOBY	7	YOUSEM	
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "any Injury or other traumatic event, the Mones.		19a. Informant's Name/Relationship		19b. Mai	ling Address (Street	and Number or Rui	al Route Number,	City or Town, State, Zi	p Code)
≥ .	and and and and and and and and and and		ZELDA LIPNICK/SI	POUSE		FALLSTAF	Commence of the Commence of th		MORE, MD 2	1209
ore	M Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	-	ematory or other plac	cθ)		t0c. Location - City or T	own, State
Ë	Pag tment tant: jury		4 ☐ Donation 5 ☐ Other (Spe	cify)	SWINICHE	R WOLINER	9/21/	/2008 B	BALTIMORE,	MD
Baltimore,	Depar Impor Impor In In		21. Signature of Funeral Service Lie	censee		22. Name and Addre	20	L LEVINS	ON & BROS.	, INC.
	40380					900 REIST	ERSTOWN F	D: BALTI	MORE, MD 2	1208
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the one cause on each line.	ne death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. Que	h pu	1 v Cesch	el 14	asit		215min
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		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):	ordery	dire	re		76 mours.
k'	uted d ansit	m L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	H	La Lea	0.00			-	76 moullis.
O.	be executed ician and burial-transit	Examiner	resulting in death) Last	Due to (or as a	consequence of):	310		-	- /	, 0, 0
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Вох	ath ce itendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2		☐Ectopic pregnancy	/		23d. Date of delive	*
0	that the death certifica ed by the attending ph detached for use as th	Completed by Physician/Med	1 Yes 2 No	4□Pregnant at tir 9□Unknown	me of death 5	Other (specify)			Month	Day Year
P.O.	hat the	P	Part II. Other significent condition:	s contributing to death but	not resulting in the	Underwing cause give	en in Part I	23e Oid tob	acco use contribute to	the cause of death?
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>	ysicis s cert direct	To B	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	ent 3□ DOA Oth		h <i>Check only of</i> e	nce 6 □Other (Spec	6.)
0	er thi	i.	27. Manner of Ceath	28a. Date of Injury (Month, Day )	28b. Time	of 28c. Injur	y at	28d. Describe how		197
Ö	ath. er: Aft	atio	Natural 5 ☐ Pending  Accident investigat		(ea <i>r)</i> Injury	Wor M 1 □	Yes 2 □No			
<u>×</u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		- At home, farm, s	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
Ω	ital o irs aft ral DI						1			
	Hosp 4 hou Fune Fely fil	icai	Check only 2 Medical Ex	Physicien: To the best of aminer: On the basis of e	xamination and/or i	ith occurred at the tir nvestigation, in my o	ne, date and place, pinion, death occur	and due to the car	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Medicai	one) 29b. Signature and title of certifier	and manner state	a.	29c. Licens			d. Date signed (Month	
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•			30. Name and address of person wh	NV V	th (Item 23a) /Tuna	Print)	10/0	4	11.6	006
	10		WI AM A	Ompleted cause of dea	1 D 4 2	34 412	Solmelo	e ane	-	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's	s Signature	1-	-0-0-0			
	Registr	ar	SEP 2 3 200	B frague 1	the Apare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 2. Date of Death Month Year **Physician** /Medical 2008 Town or Location of Death 4c. County of Death Examiner MOF 8. Date of Birth (Month, Day, (In yrs. last birthday) Under **Funeral** Min. 1 □ M 2 KF Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County City, Town or Location 10d. Inside City Limits r 28a-f sho notified a 1 **2** es 2 □ No Funeral Director none Street and Number 10g. Citizen of What Country? 10f. Zip Code Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n death Was Decedent Ever in U.S Armed Forces? American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan Be Pages 1 and 2 should be finent of Health and Mental Int: If item 27 is marked of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burial 2 UCremation 4 Other (Specify) Burial 2 □Cremation 3 □Removal from State 21. Signat re of Funeral Service Licenses MO1363 23a. Part r. Enter the disease, or con plications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death g, such as cardiac or respir tory arre Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an autopsy perform 1∐ Yes 21/2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ۴ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 🔀 Natural 5 Pending investigation death. 1 🗌 Yes 2 Accident 2 No after death 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 0

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31. Date filed (Month, Day,

egistrar's Signat

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			For State Registrar	State of N	Marylar	-	artment rtificate			and N	/lental Hy	gien Reg. N	Ph 170	08	30	401
п	Physici	an	1. Decedent's Name (First, Middle	, Last)		Mada					Date of De Month	D	Day	Year		of Death
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	Examir	er	Gilchrist Center		er)		4b. City, To	OWSC		Death		- 1	ic. County Baltii			
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under 1	Year_	If Under 2		8. Date of Bir (Month, Da			9. Birth	place (Stat	e or Foreign
	Director		216–32–8026	1 XM 2□ F	78	8 Yrs.	Months	Days	Hours	Min.	November	18,		Mary		
	and		Usual Residence of Decedent  10a, State 10b, County		10c Cit	ty, Town or Lo	cation							1.	10d. Inside	City Limita
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	r 28a	irec	Maryland Balti 10e. Street and Number	more_	EX	dgemer	10f. Zip C	ode				10g. C	Citizen of V	What Cour		
	th with	Funeral Directo	9205 Cuckold Poi	.nt Road				2121	9				USA			
	tems termi	nuel	11. Marital Status	12. Was Deceder Armed Force	s?	.S. 13.	Was Deceder	nt of His Cuban	spanic Orig	gin? (Sp	ecify Yes or No Rican, etc.)	)-		e - Americ	can Indian,	
36	s afte	by F	1 ☐ Never Married 2 🔀 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	□No	1	1 □ Yes 2		Specify:	,	, , , , , , , ,		Specify	r.71		
9	2 hour	led t	15. Decedent	Year or Dates s Education	S:	16a. Dece	dent's Usual	Occupa	tion			16b.	Kind of Bu	ısiness/In	dustry	
212	hin 72 9. am "ng Media	ple	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4o	r 5+)	ı (Give	kind of work DO NOT use	done di	ırina most	of work	ing		Time of Be	2011/000/111	acony	
7	be filed within 72 hours after death with the Maryland Hygiene. dother than "natural", or items 23a or 28a-f show event, I'm Medical Evaning must be notified at	Completed	12 years			Arabe	er					Pr	coduce	e		
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saltimore,	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			emetery, crer ed <b>Heart</b>			າ ¦ ວ ∋m.	3, 2	2008	Dund	dalk,	Mar	yland	
<u>a</u>	permit. Page Department of Important: If any injury or once.		21. Signature of Full eral Service I	icensee	111					-		Para	lalk	D 7		
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2 3	er deg recto	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of I	njury - At ho etc. (Specif	me, farm, stre	eet, factory, o	ffice		:	28f. Location (S City or Tou	Street a	and Numbe	er or Rura	l Route Nu	mber,
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	Stat		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture										

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9/ 21/2008 12:55  $P^{M}$ <u>Alfred</u> Nelson Malone /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Paltimore 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 214-24-2629 78 3/21/1930 NY Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1611 Dukeland Street 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status African Specify: 1 Never Married 2 Married 1 □Yes 2X No Yes, Give Specify: Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Truck Driver Woodlawn Motor Coach 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Nelson Pearl Brown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Jackson / Daughter 517 West Lafayette Avenue Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9/ 23/2008 Paltimore, Maryland <sup>22. Name and Address of Facility</sup> Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road Randallstown, Maryland 21133 21. Signature of Funeral Service Licensee hone K 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can see on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE disease or condition resulting in death) DAYS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) \( \text{HOSFILE} \) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner

use as the burial-transi sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran filled in by the funeral director,

certificate

After this

after death

24 hours a

To the within 2

Hospital or Attending Physician: 24 hours after death.

The law requires that the death certificate be exect

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LONE

**Funeral** 

Director

show

d other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at

h and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur

**Physician** 

/Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore.

Completed by Physician/Medical Be

ca

29a, Certifier

Certification: To

27. Manner of Death 1 X Natural

29b. Signature and title of certifier

5 Pending investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide 4 ☐ Homicide

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D64395 SEPTEMBER 21, 2008

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NOHAPLES ST, SUITE 209 BACTIMORE, MD 21204 DANIEUE DOBERMAN. mo

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 6:00am M Rosella May Moore September 22, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29 Caltriders Lane Baltimore Reisterstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 ☐ M 2 🖺 F PA Director 219-20-3282 83 11, Aug. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2X No Baltimore Reisterstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or pe ıral", or items 23a Examiner must t 29 Caltriders Lane 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or Item 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖔 No Specify: à 3 Widowed 4 ☐ Divorced White Completed item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Melvin W. Garrett Manni Spanger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Thelma Schlerf 93 Bond Street, Westminster, MD 21157 Dermit. Pages.
Department of Her Important: If iter
'viury or o' 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll 9/23/08 Cremation Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 0 27 N resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 mon 1 Yes 2 No Month Year months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 autopsy performed? 1 Yes 2 No certificate To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2N No Hospital: Other: 4 \( \sum \) Nursing Home 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Alatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 349 MI) 2115 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 23

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year 0431A 2008 September 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAND MED I If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 🕅 M 2□ F Days Hours Min 88 084-14-6401 Director March 1920 NY Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Nedical Examinating the Internal and injury or other traumatic event, Ire Nedical Examinating the Internal and injury or other traumatic event, Ire Nedical Examinations. Director MD Carroll Sykesville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue C - 01921784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If ¥es, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐Yes 2 🌠 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housing & urban develop. economist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Blumenthal Eva Metcalf ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Metcalf (spouse) 7200 Third Ave., C-019, Sykesville, MD 21784 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State All County Cremation 9-22-08 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel M00764 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DRONACY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of): Examine Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. led by the a detached if signed I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by YPERLIPTOEMENTA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should SLEEP APNEA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ormed? 2 No 2 No Division of Vital 1 ∐Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident filled in by the Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEATHER SHEETS 22 5. GR BALTIMOKE MD 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

08-07101	
Deborah McGee	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 30405

	1- For State Registrar	Certificate	of Death	Reg.	No.				
Physician/	Decedent's Name (First, Middle,Last)			Date of Death     Month	3. Time of Death				
Medical Examine	DEBUKAH MCGEE		Table 21 Tab	September	17, 2008 1118 nrs				
	4a. Facility Name (if not institution, give street 3822 Chestnut Road	and number)	4b. City, Town, or Location of Middle River	of Death	4c. County of Death Baltimore County				
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)			MM/DD/YYYY) 9. Birthplace (State or Foreign				
Director	215-78-3396 1□м 2	X F 46	Yrs. Months Days Hours	NOV. 10					
A	Usual Residence of Decedent  10a. State 10b. County	110c. City, Town or Lor	ootion		40d Incide City Limite				
ow any					10d. Inside City Limits  1 X Yes 2 No				
Marykand 28a-f show d at once.	MD BALTIMORE  10e. Street and Number	MIDDLE RI	10f. Zip Code	100	. Citizen of What Country?				
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with 1 with 1 be not			Was Decedent of Hispanic Orig	in? ( Specify Yes or No-	14. Race - American Indian, Black,				
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hours frank	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	est grade completed) 16a. Deceding	dent's Usual Occupation (Give l g most of working life. DO NOT		6b. Kind of Business/Industry				
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5-0036 filed within 7 Hygiene. to other than the Medica	17. Father's Name (First, Middle, Last)	, nov		s Name (First, Middle, Ma	110124				
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MD 2121 d 2 should be fi th and Mental n 27 is marked tumatic event,		A.			er, City or Town, State, Zip Code)				
e, MD Tand 2 sho Health and item 27 is	MELISSA MAYES/DAUGHT		C KOSOAK RD., N		, MD 21220 20c. Location - City or Town, State				
2	1 Burial 2 X Cremation 3 Rer			Date	Location - City of Town, State				
Baltimo permit. Page Department of Important: injury or oth	4 Donation 5 Other Specify: 21. Signature of Funeral Wice Licenses		DENT	09/19/2008	HANOVER, MD				
Bal Depa Impo	21. Signature of Puneral Salvice Licensee	+l. $l$ "	2007-09 EASTER		IS, JR. FNRL. HM. TIMORE, MD 21231				
Physician	23a. Part I. Enter the dise e, or complication	s that caused the death. Do not enter	er the mode of dying, such as c	ardiac or respiratory arrest	t, shock, or heart Approximate Interval				
/Medical	23a. Part I. Enter the diser le, or complication failure. List only or a cause on each line immediate Cause (Final disease a.	ardiovascular Di	sease	cating Atne	Death				
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8760, ifficate be ng physici sthe buri	23h Was decedent pregnant in the	If yes, outcome of pregnancy Live birth 2	Fetal death 3 Ectopic	pregnancy	23d. Date of delivery  Month Day Year				
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). Box 68 the death certife by the attending tached for use as Physician	1 Yes 2 No 9 V Unknown g	Unknown							
P.O. s that the greed by detach	Part II. Other significant conditions contrit  Emphysema, Proba		ie underlying cause given in Pa		acco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown				
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death.  sal Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated bertification: To Be Completed by P	25. Was case referred to medical examiner?	1 Inpatient 2 ER/Outpatie	26.Place of Death ent 3 DOA Other		esidence 6 V Other: Scene				
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Division o spiral or Attending nour steer den. neral Director: Aft filled in by the func	Z Accident investigation	e. Place of Injury - At home, farm, si		c. 28f. Location (Str	eet and Number or Rural Route Number, City				
Spital Spital hours & hours & Cert	4 Homicide determined (S	pecify) house		Middle	8 3822 Chestnut Rd. River, Md.				
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex	one) 2 Medical Examiner:On the	the best of my knowledge, death oc basis of examination and/or investi- anner stated.							
Me a se a	29b. Signature and title of certifier	surio otatoa.	29c. License number	[2	29d. Date signed (Month, Day, Year)				
O. ili	(Moto)		O.C.M.E.	:	September 18, 2008				
penco	30. Name and address of person who completed cause of death (Item 23a)								
		dical Examiner 111 Penn 32. Registrar's Signature	Street, Baltimore, MD	Z 1201					
State Registrar		Bearing M. A.	mall y						
DHMH 17 Rev 1/2001	17 421 10 0 0	ORIGIN	IAL						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Sephinher 6:50 AM 2008 illie 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 1 DM 2 XF Days MAY 28, 1926 MD 220-14-2778 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21202 914 E. EAGER ST. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Specify: 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE 10TH HOUSEKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN WALKER SARAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1433 E. EAGER ST., BALTIMORE, MD 21205 LILQUENDA BIVINS/GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location City of Town State 5500 O'DONNELL ST. 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY 09/25/2008 | BALTIMORE, MD\_21224 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease for complications that cause of shock, or heart failure dist only one cause on each fine. Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) electrical achvily pulselias ue to (or as a consequence of) myocardial interchar Due to for as a consequence of, diserva Due to (or as a consequence of): arterv 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was aп autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify)

Examiner iding physician and use as the burial-transit The law requires that the death certificate be executed of Vital Records, P.O. Box 68760, attending p ate has been signed by the a page 2 should be detached certificate or Atter ding Physician: eral Director After this certificatilled in by the funeral director, Division 24 hours arer death. Hospital

Physician

Examiner

10a. State

MD

Director

Funeral

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Completed

Be ဂ္

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.

Physician

/Medical

Baltimore, Maryland 21215-0036

death with the Maryland

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 \sum Nursing Home မှ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29c. License number 29d. Date signed (Month, Day, Year)

within 24 ho

To the Fune

completely f

State Registrar

Orecki Zoé 31. Date filed (Month, Day, Year)

SEP 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MPH mo

MOMPH

32. Registrar's Signature

RES - 000

September 21, 2008

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year KENNETH Ε. MONTGOMERY 14034 SEPT 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace
 Country) **Funeral** Days Hours 1 (3 M 2 □ F 578-68-6150 58 Yrs. Director JULY 2. 1950 **ALABAMA** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 TYYes 2 □ No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44th ST., #2 306 N.E. 20019 permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, Ite Medical Examinant on the Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: 2 Specify Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2Yr Elementary/Secondary (0-12) NURSING AID HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES MONTGOMERY ELIZABETH PRUITT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELMARIE WILLIAMS/COUSIN 200 CLOSHIRE DR., BIRMINHAM, ALABAMA 35214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY | 9/19/08 BELTSVILLE, MD. 21. Signatu Funeral Service Lighnses 22. Name and Address of Facility 20002 CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WASH., complications that caused the death. The mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to kr as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last un Examine Due to (or as a consequence of) The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No autopsy performed? 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mer of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Moph, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Demetrios James Catevenis 3100 Hospital Dr. Cheverly, Md. 20785 31. Date filed (Month, Day, Year) \$\frac{SEP 2 3}{2008}\$ . Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 10:30 AM September 16, Gertrude Μ. Metallo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Future Care @ North Point Dundalk If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 08/23/1923 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 X F Mary land 85 Director 219-10-4395 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Edgemere MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21219 USA 2401 Oak Manor Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ģ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Graves Jenny 2 Beverly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathleen M. Borkman (daughter) 2401 Oak Manor Rd. Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 09/19/2008 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Sign, ure of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of MD. 21222 Dundalk, Inq. 7922 Wise Ave. Dundalk, 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 | Johknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 24 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Man or of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 Yes 2 No death. 2 Accident filled in by the Director 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral [ 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division or Vital Records, P.O. Box 68760, Hospital

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Walke

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

bods load.

29d. Date signed (Month, Day, Year)

**Physician** 

/Medical

Examiner

10a. State

MD

Director

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Completed

Be

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

State

IF FEMALE:

Natural

29a. Certifier

(Check only one)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20, 2008 Year Sept. 4:00 aM Nelson Clarence Herbert 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Best Care Assisted Living Reisterstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 30, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours New Jersey 1926 82 145-14-5840 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Owings Mills Baltimore 10g. Citizen of What Country? 10e. Street and Number 21117 USA 4828 Stone Shop Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Aeronautical Engineering Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelson Katrina Andreassen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4828 Stone Shop Circle Owings Mills, MD 21117 Edith R. Nelson Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Eldersburg, MD. 9/24/08 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem Park 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Seffice Licensee 21136 10 ansins Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that consequences shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emen Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of). 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 200 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

burial-transi ed by the attending physician detached for use as the burial To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Physician

/Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center 10 WINGS 31. Date filed (Month, Day, 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician GERTRUDE ELT ZABETH NOVAK SEPTEMBER 2:30PM 22,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HERITAGE NURSING CENTER DUNDALK BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 87 5-26-1921 213-16-1384 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If them 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modified at 1 ☐ Yes 入口No Director MD BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1504 CAVEL ROAD 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by Specify: WHITE 3√Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANK DUNNIGAN ELIZABETH (NAGENGAST) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD J. NOVAK/SON P.O. BOX 44428 BALTIMORE, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) PARKWOOD CEMETERY 9-25-2008 PARKVILLE, MD 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service dee 21237 1211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar physician Physician/Medical the as attending IF FEMALE: ase If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☑No P.0. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 2 No 1 □Yes 2 No 1 □ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 1 ☐ N Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: ₽ investigation the Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

23

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FERNETTE SAINT NICHOLS /Medical September 14. 2008 0805 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BETHESDA 1 Year | If Under Days | Hours SUBURBAN HOSPITAL MONTGOMERY 5. Social Security Number 6. Sex 1 □ M 2 □ √F If Under 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) Months Yrs Director 577-64-5165 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Funeral Director 1 Yes 2 No D.C. Washington 10e. Street and Number 10g. Citizen of What Country? 1821 Sudbury Lane, N.W. 20012 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 → No þ Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Preacher Ministry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Freeman C. Nichols Carrie Harrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lynette Nichols/Sister</u> 2040 Mayflower Dr. Silver Spring, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Olivet Cemetery 9-19-08 Mt. Funeral Service Litensee/ Washington, D.C. 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash. DC omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final Brews **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Box 68760, physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 2/1 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 ☐Yes 2 ☐No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) within 24 and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 00055480 M'MSpring 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brendy (a mod SUBURBAN HOSPITAL Bethesda, Md. 20814 31. Date filed (Month, Day, Year) SEP 2 3 2008 32. Registrar's Signature

State Registrar

			Pleas	se Type or Pri					•		•	
			1 - For State Registrar	State of M	arylan		rtment of h tificate of		d Mental Hy	/giene Reg. No.	2008	30412
п	Physici	an	Decedent's Name (First, Middle	,					2. Date of Do Month	Day	Year	3. Time of Death
	/Medio		Marjorie 4a. Facility Name (If not institution)		ughe	es .	4b. City, Town, o	r Location of De			20,2008 County of Dea	
	Funeral		Greater Balti	more Medical		ter	Towson	n	rs. 8 Date of Ri	rth	Baltimo	
	Director		231–38–3127 Usual Residence of Decedent	1□M 2 <b>X</b> )F	76	Yrs.	Months Days	Hours M	09 18	3 3	2	VA
	show	ō	10a. State 10b. County	····		y, Town or Loc		-				10d. Inside City Limits 1 XYes 2 ☐ No
	the N	Director	MD NA 10e. Street and Number		E	Baltim	10f. Zip Code			10a. Citiz	zen of What Co	
	th with 23a or	al D	2500 West Bel	lvedere Av	e Ap	t 203	2	21215		J	U.S.A	
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. V	as Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or Noterto Rican, etc.)	0- 1	4. Race - Ame Black, White	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural" or items 23a or 28a-f show raumatic event, If a Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3X Widowed 4 ☐ Divorced	ed 1 ∏Yes 24∏ I If Yes, Give Year or Dates:	No .	1	□Yes 2 No	Specify:			Specify: B]	
15-(	n 72 h "natu edicel	Completed	15. Decedent' (Specify only highes	s Education grade completed)		16a. Deced	ent's Usual Occup ind of work done O NOT use retired	oation during most of v	working		d of Business	Industry City
212	d withi giene. ir than	omp	Elementary/Secondary (0-12)  12th grade	College (1-4or 5 5yrs+	i+)		eacher	-/			lic Sc	-
g	oe filed tal Hy d othe event,	Be C	17. Father's Name (First, Middle, L	ast)					Name (First, Middle		,	
<u> </u>	d Men d Men narke natic	မ	Linsay Hughes	5		Line was			lia Tho			
	permit. Pages 1 and 2 should be Department of Heath and Ment Important: If item 27 is marked any injury or other traumatic e once.		19a. Informant's Name/Relationsh Cassandra F.	Washingto	hter	19b. Mailing	Cooks		Rural Route Numb Baltime			Zip Code) 21229
ore	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition  X☐ Burial 2 ☐ Cremation	B ☐ Removal from State			ition (Name of atory or other place		Date		cation - City or	·
	nit. Pa artmei ortant injury e.		4 ☐ Donation 5 ☐ Other (Sp		Gar		Forest Name and Addre		9/25/08	Owli	ngs Mi	ills, Md
ñ	permit. Departr Imports any init	-	Demald C	Quiant		Ma	rch F/F	H West	e, Balt	imor	БМ .e	21215
	e		23a. P. ot 1. Enter the disease, or of shock, or heart failure. List of	omplications that caused nly one cause on each lin	the death							Approximate Interval Between
F	hysician /Medical		Immediate Cause (Final sease or condition resulting in death)	-a. Ceres	rova	scular	Accide	1+-Mu	itiple			Onset and Death  _ ( mon + h)
, <sup>,,,,1</sup>	xaminer			Due to (or as	a consequ	ience of):						
	nsit	xaminer	Sequentially list conditions, if any leading to hime dide cause. Enter Underlying Cause (Disease or injury	Due to (or as	a curisuqu	ence of):						
9	executed in and fal-transit	Exan	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):						
09/89	earn certificate be e attending physician for use as the buria	dical		d								
×	cernincate nding physi use as the l	/Me	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ncy	_			20	3d. Date of de	livory
	he atter	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 █No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 🗆	Ectopic pregnanc Other <i>(specify)</i> _	у		2	Month	Day Year
7	ed by t detach		9 ☐ Unknown  Part II. Other significant condition		ut not resu	Iting in the un	derlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
ords	requires that the been signed by the hould be detache	ed by	Pulmonary hy, Right hear						_ 1□	Yes 2□	] No 3 ☐ Pi	robably 4 Unknown
Records,	aw 2 sl	Completed	Right hear	t failure					24a. Was		24b. Were au prior to death?	utopsy findings available completion of cause of
_ F	an: 11 tificate tor, pa	Be Co	25. Was case referred to medical	1				26 Place of F	1 □ Yes	2 No	1 ☐ Yes	2 🗆 No
V 10	nysici his cel		examiner? 1 ☐ Yes 2 🕰 No	Hospital: 1 🔀 Inpatie	nt 2 🗆 E	ER/Outpatient	3 ☐ DOA Oth		Home 5 ☐ Res		☐Other (Spe	cify)
ס בוס	After t funera	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Day	ry /, Year)	28b. Time of Injury	28c. Injur Work M 1 🗆	y at ⟨? Yes 2 □ No	28d. Describe	how injury	occurred	
DIVISION	er deal rector: by the	tifica	3 Suicide 6 Could no determin	t be Tage Place of Inju	Iry - At hor	me, farm, stree		100 12.110	28f. Location (	Street and	Number or Ru	ural Route Number,
5	ours aft eral Di filled in		29a. Certifier									
	To the Troppia of variatining trystician; the within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examinat	ion and/or inv	estigation, in my o	pinion, death or	ace, and due to the courred at the time,	date and	and manner as place, and due	s stated.  to the cause(s)
1	To t To t	Ž	29b. Signature and title of certifier	1.			29c. License	-0 -			signed (Mont	
	5		30. Name and address of person w	ho completed cause of de	eath (Item	23a) (Type. P	1)4/7			Sept	ember	21, 2008
	O		Bunne ishen	MD 670	IN	Charl	es stree	t Bai	Himore	MO	2120	4
	Stat Registra		31. Date filed (Month, Day, Year)	Sz. Registre	ii s Oigilati	ui e	Water Street					
DHM	H 17 Rev 1/20		SEP 23	2008 Julien	Red all	1 100	well					

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Zoof **Physician** Month ade 0:2(AM ptember 22 e /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 51 Nursing timor Izabeth Cent PY Sa Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1 ☐ M 2 🛛 F 212-01-6710 Director Yrs. 93 Oct.5. 1914 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 325 Waveland Road 21228 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If itam 27 is marked othar than "natural; or iten any injury or other traumatic avant, the Medical Examinat once. Black White etc. 1 Never Married 2 Married Baltimore. Marvland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry completed) Elementary/Secondary (0-12) College (1-4or 5+) Archdiocese of Baltimore 10 Executive Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Ernst Elizabeth Gilmore 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth G. O'Connell-Daughter 325 Waveland Road; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) ` 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery n Cemetery 19/27/2008 Woodlawn, Maryland
22. Name and Address of Facility Sterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc. 9/27/2008 21. Signature of Fun ral Service Licensee 190/490 1630 Edmondson Avenue; Catonsville, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** emen disease or condition resulting in death) VEOWS /Medical Due to (or as a consequence of): **Examiner** emj betes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit be executed envi ynertension consequence of): P.O. Box 68760, attending physician Luonan Physician/Medicai The law requires that the death certificate IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) the detached 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 No 3 Probably 4 □Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1 🗌 Yes 2 No 1 🗌 Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Magner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attanding 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 22 30. Name and address of person who completed cay so of death (Item 23a) (Type, Print) Ming 0 MO enson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death edent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day Year **Physician** 5 = 04 PM uanno 09 16 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. Date of Birth (Month, Day Social Security Number 7. Age Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 M 2 K Months Days 215-07-3592 Director Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examiner must be notified at 1 ☐Xes 2 ☐ No **Funeral Director** timore 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of n ary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition Burial 2 Cremation 3 F 3 Removal from State 21. Signatu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirators shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): **Examiner** Right third toe wound infection, questionable pneumonia Sequentially life conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Multiple organ failure attending physician and Due to (or as a consequence of): Box 68760. intravascular coaquilation Physician/Medical Disseminated 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 End stage renal disease on hemodialysis 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Corenary artery disease 24a. Was an autopsy The After this certificate 1 □ Yes 2 □ No Diabetes Mellitus Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RESOOO 16 M.D 12008 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) MD 10 Loch Raven Blud Good Samaritan Hospital, Baltimore 5601 FANG YIN 21239 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

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Certificate of Death

Reg. No.

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1 - For State Registrar

Examiner attending physician and for use as the burial-trans signed by the a cate has I page 2 s eral Director: After th within 24 hours a To the Funeral I

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 21, Month **Physician** 7:00 P.M Donald Charles Perricone, Sr. September 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 2730 Old Fort Schoolhouse Road Hampstead 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** XM 2□F 80 Mar. 31, New York Director 056-22-6108 1928 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes ŽXNo Director Maryland Carroll Hampstead 10g, Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 2730 Old Fort Schoolhouse Road 21074 of America o- | 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1945— MXYes 2 No If Yes, Give Year or Dates: 1953 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married XX Married 1 ☐ Yes 20XNo Specify Specify: 9 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Technologist Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bennie Perricone ဥ Sarah Ciccone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2730 Old Fort Schoolhouse Road, Hampstead, MD 21074 Iris M. Perricone (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sep. Metro Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 21. Signature of Fungral Service Licensee 22. Name and Address of Facility. Eckhardt Funeral Chapel, P.A. John Serrash 3296 Charmil Drive, Manchester, Maryland 21102 23a. Part ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hoof, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ess ( wh) disease or condition resulting in death) Due to (or as a consequence of): Kidne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops, performe 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 No Hospital: 1 ☐ Yes Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA P 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enth Drive Jushner MI) Business

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month)

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Dorothy Roberts September 18, 2008 5:00 Α /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Middle River Baltimore 404 Crisfield Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕱 F 85 217-12-7635 Yrs **Director** September Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modert Examinar must be notified at Baltimore Middle River MD. 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 404 Crisfield Road 21220 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 27 No Specify: White à 3 ☐ Widowed 4 ₺ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Secretary 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental item 27 is marked o Pages 1 and 2 should be Viola Makin Walter Carr 2 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code)
404 Crisfield Road, Middle River Maryland 21220 19a. Informant's Name/Relationship (Type. Print) Karen Coffey / Great Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September Department of H Important: If ite any injury or ott once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial 23, 2008 Middle River, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk,
7110 Sollers Point Road, Dundalk, 21. Signature of Funeral Service License ron 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Denydration **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner imer 72 M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for 1 □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes P No 1 ☐ Yes 2 ☐ No 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Sta Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending r death. tospital or Attendii
hours after death.
uneral Director: A 1 □Yes 2 □ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Shudelo-Physican 09-18-2009 D39758 Philadelphia RD Suite 300 BAUTO, MD.

10

31. Date filed (Month, Day, Year) State SEP 23 Registrar



9114

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 4:00 PM **Physician** Ruth В Rocks 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Baltimore City Good Samaritan Hospital 8. Date of Birth (Month Day, Year) July 26 1923 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Baltimore, Maryland 1 □ M 2 □ F 217 18 5740 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventmet must be notified at 1 ☐ Yes 2X No Baltimore Baltimore County Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 2904 kings Ridge Road Apt. D Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 \_Yes 2X If Yes, Give Year or Dates: 2X No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) Rental Agent & Homemaker Housekeeping own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theurer Charles Kossman Augusta Kossman ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 302 Donald Circle Forest Hill, Maryland 21050 Dan C. Rocks (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date Parkwood Cemetery September 23 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licersee 22. Name and Address of Facility
Lassahn Funeral Home Inc. 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** pneumonia ossible aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Possible clostridium difficile colitis burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical infarction Myocardial the as attending properties of IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 MNo 3 🗌 Ectopic pregnancy Day Month Year 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det ģ failure on chronic renal 2 🔽 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary artery disease 24a. Was an autopsy Hypertension 1 ☐ Yes 2 ☐ No 1∐Yes 2∭2No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Npatient Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RESOOO M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

1

Good Samaritan Hospital
(Year) 32. Registrar's Signature

5601 Loch Raven Blvd, Baltimore MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** JOHN WILLIAM SCOTT SEPTEMBER 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death Examiner DOVE HOUSE WESTMINSTER CARROLL Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F 217-48-427 Director June 16. 1954 MARYLAN Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 res 2 No Director YORK SEVOULTH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1016 YORK 17331 TREET Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☑ Divorced "natural", Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTON CARPENTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be f and Mental F WILLIAM CROOVS 54079 MARGARET 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra RICHARDKOT ROAD, WESTMINSTOR BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HAUDVAZ MARYLAN ANATOMY GIFTS PLLISTRY SCATTORERED, 4 Monation 5 ☐ Other (Specify) 22. Name and Address of Facility
ALBTONE WEST TSUSTED
7533 CONSELLEY DO. S 21. Signature of Funeral Service Mensee DR. STEP STOIC DM SWOCKEY Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in a chiline. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of burial-transil physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 2 No 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes 2 No certificate 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 6 Other (Specify) HUSPLQ this After thi funeral of 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person ward MD Westminster Street

DHMH 17 Rev 1/2001

State Registrar

Center

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 *iantambay* /Medical y of Death 4b. City, Town, or Location of Death Examiner Baltimore andallstown HOSDIGE Date of Birth (Month, Day, Ye 3-24 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. 5. Social Security Number **Funeral** Min Days Hours 1 □ M 2 ☐ F 0614 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 211 source Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify. Blac 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nentary/Secondary (0-12) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mangone. College (1-4or 5+) 17. Father's Name (First, Middle, Last) altimore, Maryland 18. Mother's Name (First, Middle, Maiden Surnan Be ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R. al Route Number, City Son 4014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Live see - Mo1401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE RENAL FAILURE END /Medical Due to (or as a consequence of): Examiner DIABETIC NEPHROPATHY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-t Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ☐Yes 2 No sate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certific letely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) SONSOWS Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 2008 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

nth, Day, Year)

SEP 2

2008

32. Registrar's Signature

RESTONSTOWN MO

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend item 20b per in 8884 10-7-08 vt
State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last, 3. Time of Death Year **Physician** Settle 8:53PM rnestine 2008 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore HOSPICE lowson 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 □ M 2 🔀 F -.9290 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1∩a State 28a-f show traumatic event, the Medical Exerctions count by notified at NIA MD Baltimore 1 XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Avenue USA 5125 Nelson 2125 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Rems 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐Yes 2 No Specify: Specify: Black 2 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1,4or 5+) n and Mental Hygiene. Elementary/Secondary (0-12) HealthCare Medicine Aid 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Brown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Avenue Baltimore MD 21215 5125 Nelson Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 10 103 Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MID 26/08 Garrison Forest 22. Name and Address of Facility Vaughn C Greene Funeral SVCS 21. Signature of Funerel Service License 8728 Liberty Road Randgilstown MD 21133 C. Van 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONTHS **Physician** PANCREATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months?
1 □ Yes 2 □ No 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an autopsy performe 1 □Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Frashme Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. the 29c. License number **D64395** 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIELLE DOBERMAN MO 6565 N. CHARLES ST. SUITE 209 BALTIMORE, MD 21204 32 Registrar's Signature 31. Date filed (Month Pay Year) 2008 State

Registrar

2008

September

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3004 M 10 09 /Medical 4a. Facility Name (If not institution give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Randallstown rason's Hospice - Northwest Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day 08 17 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 X M 2 ☐ F Months 218.60. Jamaica Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the the dical Evan, items, the trailing as 1 ☐ Yes 2 No MD Baltinore Director Oak 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 3910 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Automotive Mechanic 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sowell Sewell Michael vedrica 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. Martinsburg WV 25405 20N Lenworth SeWell Drive) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, MD 09/29/08 Resurrection Acres 4 Donation 5 Other (Specify) Vaudon C. Greene Funeral SICS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility - Road Pandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pneumonia Due to (or as a core **Physician** /Medical (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran and Due to (or as a consequence of) Box 68760, physician s the burial Physician/Medical attending IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ed by the detached Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ hypertension, aiayetes, altheima i demonna 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate 1 ☐ Yes **Division of Vital** 1 ☐ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , сотрletely filled in by the f filled in by the 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifi 2008 D60690 30. Name and address of person who completed cause Cause of death (Item 23a) (Type, Print)
HICITECTUN 7D HUNG LESTENTUM, MD 21136 3

State Registrar 31. Date filed (Month, Day, Year)

SEP

2008<sup>32. Redistrar's Signature</sup>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 845 PM **Physician** SANDERS SEPTEMBER 19 2008 JUANITA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOS PITAL BATIMORE BON SECOURS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 🔀 F Months Hours Director 29 SC 219-32-9633 Usual Residence of Decedent 34 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director X□Yes 2□No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21216 2313 Riggs Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify Specify: Black þ ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Assembly Operator Shoe Factory <u>llth\_grade</u> na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ' Lou Ellen Carter မ Verian Dunbar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau 2313 Riggs Ave, Baltimore, Md 21216 <u>Vivian Deaver--</u>Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date X□ Burial 2 □ Cremation 3 □ Removal from State Loudon Park 9/26/08 Baltimore, Md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Pary . Enter the disease, or complications that disease have death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line Imp diate Cause (Final disease or condition resulting in death) **Physician** BREAST METASTATIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL EAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 ☐ Yes 2 **\\_K**0 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours a er death investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Records. Division of Vital Hospital 24 hours within 2

> State Registrar

DHMH 17 Rev 1/2001

completely

(Check only one)

THOMAS

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MILLON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1)30272

BALTIMORE, MO

29d. Date signed (Month, Day, Year)

08-07060 Charles Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

rles S	Scott		E - Chaha	State	of Maryland	/ Depart Certit	ment of F ficate of D	ieann an Death	INICITIALI	lygione	Reg. No	. 2	UU (	3 304
			- For State Registrar 1. Decedent's Name	(First Middle I a	et)	Certif	icate of B			2. Date of	f Death			ne of Death
	hysicia Examii	110	Charles			rice		Sc	ott	Septe	Day mber 15	, 2008		555 hrs
, .	<b>Examin</b>				ve street and number		4b.	City, Town, or	Location of Dea	ith		c. County of D	eath	
				Place Apt. #				Baltimore		- F. S.	( D) 11 ( O (	W/DD/YYYY) 9	Birtholace	(State or
F	uneral		5. Social Security N	Number 6. S	Sex 7. As	ge (In yrs. last	t birthday)	If Under 1 Yea Months Days		in. 8. Date	or Birth (Mi	W/DD/TTTT) 9 Fe	oreign	
	rector		214-56-	71/8 1	XM 2 F	59	Yrs.	Wionus Day.	3 Floure III	04	22	49	Country)	MD
			Usual Residence o	<u> </u>									10d.	Inside City Limits
	any		10a. State	10b. County			own or Location						1 X	Yes 2 No
72	show rce.	'n	MD	NA			Baltin				10a C	Citizen of What	Country?	
· slyre	28a-f show	Director	10e. Street and Nu	ımber				10f. Zip Code			1.53			
( ) 4 ( ) 4	s 23a or 28a-f show		2525 E	utaw Pl	ace		1.2 11	21	217 spanic Origin? (	Specify Ye	s or No-	14. Race - /	American Ir	ndian, Black,
dimin	ms 22 be no	era	11. Marital Status	ind 2 Marrie	12. Was Deceder		i, 13. Was	s, specify Cuba	n, Mexican, Pue	erto Rican, e	tc.)	White,		
land.	or ite	Funeral	1 Never Marr		Yes	2X No		Yes 2X No	specify:			Specify:	Blac	k
d	ral", riner	by	3 Widowed		ed If Yes, Give Year or Dates: only highest grade co	ompleted)	16a Decedent's	e Heual Occuna	ation (Give kind	of work don		b. Kind of Busi		try
	nour 'natu Exar	eted	Elementary/Sec		College (1-4 c		during mos	st of working life	e. DO NOT use	retirea)	Ma	arriot	t	
36	than dical	ᄀ			l yr		Guest	t Serv	ices A	id	Wa	aterfr	ont	Hotel
8	d with	Comple	17. Father's Name	e (First, Middle, La					18. Mother's Na	ame (First, N	Aiddle, Maid	ten Surname)		
215-0036	tal Hyked o	Be	Dillar	d W. B1	ue				Mary Meet and Number	1cCre	ady	City or Town	State, Zip	Code)
21	ould by Men s mar	P	10a Informant's N	Name/Relationship	(Type, Print)									
M D	12 sh th and n 27 is		Collet	ha Scot	t-Massey	-Sist	ler 270	03 Ash	tle_d emetery.	Drlv Date	e, 8	Oc. Location - 0	City or Tow	n, State
ē,	Pages 1 and 2 should be filed within 12 nours arter treatr with the rotary and nearly sensitive of Health and Mental Hygiene.  Their of Health and Mental Hygiene.  The Tannaric event, the Medical Examiner must be notified at once or other transmite event, the Medical Examiner must be notified at once.		20a. Method of D	Cremation	3 Removal from	State C	rematory or oth	er place)		100/	<u> </u>	n - 1		ма
Ö	Pages ent of int: I		4 Donation	5 Other Spec	cify:	Lo	oudon			/22/	08 ]	Baltin	ore,	Ma
Baltimore,	permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the Important, or other traumatic event, the Medialury or other traumatic event, the Medialury or other traumatic event, the Medialury or other traumatic event, the Medialury or other traumatic event, the Medialury or other traumatic event, the Medialury or other traumatic event, the Medialury or other traumatic event, the Medialury events of the medialury even		21. Signature of F	uneral Service Li	censee	- >	Ma:	rch F	H West	: _			M a	21215
<b>w</b>	P D E		CX	spette	omplications that caus	ned the death	Do not enter the	OO Wab	oash Av	iac or respir	atory arrest	, shock, or hea	Md A	pproximate Interval Between Onset and
Ph	ysiciar		23a. Part I. Enter failure. List	only one cause of	n each line.	Sed the dodan		1		017000	ular	disease	,   '	Death
	Medica amine		Immediate Cause or condition resu	e (Final disease	a. <u>Hyperte</u> Due to (or as a co	ensive	atheos	cleroti	<u>e carur</u>	Ovasc	ulai_	415045		
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		à	Sequentially list if any, leading to	immediate	Due to (or as a co	onsequence o	f):							
		miner	cause. Enter Ur (Disease or injur	y that initiated	c. Due to (or as a co	onsequence o	of):							
1	cuted	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	events resulting	in death) Last						m m				
V- 0	xecute n and	: I =			AMENDED	23a,27	,perME,	g883 9	9/24/08	TT				
Ö.	leath certificate be exec e attending physician a	3			23c. If yes, ou	tcome of preg	gnancy					23d. Date of		Year
6876	tificat ng ph	on use as no	23b. Was decede	ent pregnant in the	the state of the s				3 Ectopic p	regnancy		Month	Day	T Cal
9 ×	th cer ttendi	och i	1 Yes 2	_	4	nt at time of de	eath 5 O	ther (Specify)						
Box	ne dea	3 I 3			ons contributing to		resulting in the	underlying caus	se given in Part	i. 2				cause of death?
P.O.	ires that the	netaci	Part II. Other Si	giiiicani condin	One continue in a					1	1 Yes			oly 4 🗸 Unknown
											24a. Was ar autops		Were autor	osy findings available apletion of cause of
ord	aw requi	suonia									perform  Yes 2	ned?	death?	2 No
Sec	The la	page	E					26 D	lace of Death (C	Check only o				
-	ian: The law		25. Was case re examiner?	eferred to medical	and the state of t	actiont 2	ER/Outpatier			Nursing Ho		Residence 6	✓ Other: S	Scene
of Vital Records.	ng Physic	声	O 1 Yes	2 No		patient 2	28b. Time of		Injury at Work?			ow injury occur	red	
2	After A				28a. Date of (Month,	Day,Yaar)	l .		Yes 2	No				
.5	death	by the	2 Accider			of Injury - At	home, farm, str	eet, factory, offi	ice building, etc.	. 28f.	Location (S	treet and Numi	ber or Rura	l Route Number, City
2 ucision	l or A after Dire	filled in b	1 X Natural 2 Accider 3 Suicide 4 Homici	deter	d not be (Specify)	,					or Town, St	(ate)		
7 /	ie o					of my knowle	edge, death occ	urred at the tim	e, date and plac	ce, and due	to the cause	e(s) and manne	er as stated	i.
	F 24	completely	(Check only one) 2 29b. Signature	✓ Medical Exa	miner: On the basis of	f examination	and/or investig	ation, in my op	inion, death occ	urred at the	time, date			
	To the within 2	con	<u>ي</u> ا	and title of certifie	and manner st	aleur			cense number			29d. Date sig	ned (Mont	n, Day, Year)
			1/1.	1111	m	/	) 1	C	C.M.E.			Septembe	er 16, 20	U6
	,	1	30 Name and	address of person	who completed caus	e of death (Ite	em 23a)							-
	Ø			Ali, M.D.	Assistant Medic	al Examin	er 111 Pe	enn Street,	Baltimore, M	/ID 21201				
	1-	Siz	- 4	Month, Day Year)	32. Re	gistrar's Sign	ature	F						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	state of Ma	arylan	•	rtment tificate				R	eg. No.	8 (8	304	24
I	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Donald R. Sprigg	s							l. Date of Deat Month Septemb	Day	Year 2008	3. Time of 0	
	Examin	_	4a. Facility Name (If not institution, give stre 6214 W. Hemlock Dr				4b. City, 1 Syke		Location o	of Death		4c. County	of Death		
	Funeral Director		5. Social Security Number 6. Sex			ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birthp Coun	lace (State or try)	Foreign
	ס		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				API IO	1929	11	Od. Inside City	y Limits
	e Maryl e-f sho	ctor	MD Carroll			Sykes		<u>.</u>						1 🗆 Yes	2 <b>X</b> No
	with the	I Director	10e. Street and Number 6214 W. Hemlock Dri	ve			10f. Zip 21	Code 784			1	0g. Citizen of V USA	What Coun	try?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel', or Items 23e or 28e-1 show any figury or other treumetic event, Ire Madical Examination and once.	by Funeral	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced	Was Decedent I Armed Forces? 1 ∰Yes 2 ☐ N If Xes, Give Year or Dates:		т	Vas Decedi Yes, spec			gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)	Blac	e - Americ ck, White, v: whit	etc.	
Maryland 21215-0036	within 72 hou ene. then "nature he Modical E	Completed	15. Decedent's Educat (Specify only highest grade c		+>	life. L		k done d e retired)	uring most	t of working		16b. Kind of B		•	
land 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) Charles Hoffman Sp	riggs			<b>P</b>			,	First, Middle, M	Maiden Suman	7e)		
Mary	nd 2 sho lith and l 27 is me r treume		19a. Informant's Name/Relationship (Type, Betty Sue Spriggs (				•	,				City or Town,			
Baltimore,	Pages 1 and 2 nent of Health a snt: If item 27 Is ury or other tree		20a. Method of Disposition  1	oval from State	CE	lace of Dispo emetery, cren hany C	atory or ot	her place		Dat 9-25-		20c. Location New Win			
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee	A		764 P.	O. Bo	x 19	95 Sy	kesvi	11e, MI	cal Hom 0 21784		hapel	
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one climediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequa	uence of):	the mode	e of dying	a, such as	cardiac or r	espiratory arro	est,		Approximate Interval Betwo	veen
Box 68760,	leath certificate be executed attending physician and I for use as the burial-transit	Physiclan/Medical E	d	Due to (or as	of pregnar	ncy _						23d. Da	te of delive	ry	
o.	deat d for	hysicla	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live birth 4☐Pregnant at 9☐Unknown			Ectopic pre Other (spe					Мо	onth	Day Y	ear
ords, P	The law requires that the ate has been signed by th page 2 should be detache	þ	Part II. Other significant conditions contril	uting to death bu	ıt not resu	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did tob	oacco use cont es 2 No		e cause of de ably 4 ∐Ur	
al Record		Completed									24a. Was a autops perform	ned?	prior to cor death?	osy findings a npletion of ca 2 No	vailable use of
Vital	Physicien: this certificanal director.	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hos	pital:	nt 2∏6	ER/Outpatien	3 □ DO	A Othe			Check only on	ence 6 □Oth	er (Saecifu	·)	
Division of	Do and a		2 Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury		3c. Injury Work	at	28		w injury occur		<u></u>	
DIVIS	tel or Attendin rs after death. el Director: Af ed in by the fur	Certification;	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Inju building, etc	Iry - At hou :. (Specify	me, farm, stre	eet, factory,	office		28	f. Location (St. City or Town	reet and Numb n, State)	er or Rura	Route Numb	oer,
	To the Hospitel or within 24 hours afte To the Funerel Dirk completely filled in It	edical	29a. Certifier 1 Certifying Physici 2 Medical Examiner	an: To the best of On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred a estigation,	at the tim in my op	e, date and inion, deat	d place, and th occurred	d due to the ca at the time, da	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)	
•	To the within 2 To the complet	X	29b. Signature and title of certifier	uler			290.	License	number 30	18	2:	9d. Date signe	d (Month, 1	Day, Year)	2
	6		30. Name and address of person who comp	leted cause of de	SOU	23a) (Type)	Print)	-St	ret	LYS	funiste	r, MD	21)	57	
	Sta Registr	4	31. Date filed (Month, Day, Year) SEP 2 3 2008	32 Aegistra	1	ture	well)			- 00-		,			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 20,2008 **Physician** 10:25 p <sup>M</sup> Martha Jane Schultheis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Baltimore Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov.14,1925 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖫 F Months Days Hours Min 82 Maryland Director 212-22-3190 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location event, the Medical Examiner nust be notified at 1 □Yes 2 No Director Baltimore Maryland Lutherville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8400 Ellison 21093 USA Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Nichols Davis Martha Augustus Palm ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 Is any injury or other trau Charles Norman Schultheis/Son Salthill Court Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hillton Service Corp. 9/23/08 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Sign wire of Fund al Service Lig 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson. Md. 21204 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ONGESTIV 10000 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of) P.O. Box 68760, the burial-tran and Due to (or as a consequence of): attending physician certificate be Physician/Medical use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 힏 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) detached been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ KNo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed?

1 Yes 2 7No Hospital or Attending Physician; completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 ERNESTINE WRIGHT, 2300 DULANEY VALLEY ROAD M.D.TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 7 32. Registrar's Signature State Registrar 2008 3

SEPTEMBER

SCHULTHEIS

MARTHA

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Dorothy Stasiek 18 2008 8:30 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Raltimore, Mary If Under 1 Year If Under 24 Hrs. Pays Hours Min. Manor Care - Rossville Maryland Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/17/1925 Birthplace (State or Foreign Country) 1 □ M 2 🕱 F Months 236-16-3247 83 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 E. Fulford Avenue 21014-3816 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 XNo 1 ☐ Yes 2 🕱 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator <u> Telephone Company</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Arnold Nettie Phipps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry E. Stasiek (husband) 308 E. Fulford Avenue - Bel Air, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/22/2008 | Fallston, Maryland Highview Mem. Gdns. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Cay 11750 Belair Road - Kingsville, Maryland 00 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Year Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a Was an

**Physician** /Medical Examiner

physician

attending

the

ģ

been

certificate has

this

After

within 24 hours after death To the Funeral Director:

filled in by

completely

Hospital or Attending

Certification:

**Physician** 

/Medical

10a. State

MD

Examiner

**Funeral** 

Director

show

items 23a or 28a-f

"natural", or items 23a

notified at

pe

Director

Funeral

þ

Completed the Medical

Be

with the Maryland

filed within 72 hours after death

Hygiene.

2 should be fi

1 and 2 should

Pages 1

27 Is r Health ?

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr

Baltimore, Maryland 21215-0036

Examine burial-tra Physician/Medical the as nse for detached signed to þ Completed page 2 should Be ၉ funeral

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 mont 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed? Yes 2 No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 20 No 27. Manner of Death

6 ☐ Could not be

determined

Hospital: 1 Inpatient 28a. Date of Injury 5 ☐ Pending investigation (Month, Day

2 ER/Outpatient 3 DOA 28h Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Woods

28d. Describe how injury occurred

5 ☐ Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

**+** ☐Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

29c. License number

29d. Date signed (Month, Day, Year)

State Registra

0

8813 31. Date filed (Month, Day, 32. Registrar's Signate SEP 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-06827	
Johnny K.	Sheppard

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008	304	2
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		1- For State Registrar	Certificate	e of Death	Reg	. No.	
Physici Medical Exam		Decedent's Name (First, Middle,Last)			September	Day Year 6, 2008	3. Time of Death 0323 hrs
·		4a. Facility Name (if not institution, give stree 500 block of Nova Road	et and number)	4b. City, Town, or Location of Deat Capitol Heights	h	4c. County of Death Prince George	
Funeral Director		5. Social Security Number 6. Sex $166-64-1306$ $1_{X}$ M	7. Age (In yrs. last birthda	yrs. If Under 1 Year If Under 24Hr Months Days Hours Mi		(MM/DD/YYYY) 9. Bir Foreig , 1981 Co	
aryland 8a-f show any at once,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	Location			10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	MD PRINCE GE	ORGE'S CAPIT	10f. Zip Code	10g	. Citizen of What Coul	
th with the tems 23a of the notification of the states and the states at	Funeral D		Was Decedent Ever in U.S. 13 Armed Forces?	20743  3. Was Decedent of Hispanic Origin? (Solif Yes, specify Cuban, Mexican, Puert	Specify Yes or No-	14. Race - Ameri White, etc.	ES can Indian, Black,
urs after des	by	3 Widowed 4 Divorced If Yes or Ds	tes:	1 Yes 2 X No specify:	work done	Specify: B	LACK
y, MD 21215-0036  and 2 should be filed within 72 hours after death with the Maryland realth and Mental Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-fishe trammatic event, the Medical Examiner must be notified at once	Completed		ollege (1-4 or 5+)	ing most of working life. DO NOT use re			industry
e, MD 21215-0036  I and 2 should be filed within 7 Health and Mental Hygene, item 27 is marked other than traumatic event, the Medica	Be	17. Father's Name (First, Middle, Last) JOHNNY MCFARLAND	3.0	18.Mother's Nam	e (First, Middle, Ma EPPARD	CAPENTRY iden Surname)	
MD 21 d 2 should th and Me n 27 is ma	To	19a. Informant's Name/Relationship (Type, F JOHNNY McFARLAND/FA		lailing Address (Street and Number or 8 NORTH FRANKLIN (sposition (Name of cemetery,	Rural Route Number		DA 19140
S I E		20a. Method of Disposition  1 X Burial 2 Cremation 3 Re 4 Denation 5 Other Specify:	moval from State   crematory	or other place)		20c. Location - City or WALDORF ,	
Baltimo permit. Page Department of Important:		21. ig ature of Funeral Service Liv nsee	- Talley	22. Name and Address of Facility CAI	PITOL MOR	TUARY	20002
Physician /Medical xaminer		2 a. Part I. Enter the di. east, or complicatio failure. List only one dause on each line Immediate Cause (Final isease a Mu	ns that caused the death. It not en e. ltiple injuries	nter the mode of dying, such as cardiac	or respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and Death
Xammer	L		(or as a consequence of):	100			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence of):	<u> </u>			
e executed cian and rial - transit		d.	<sub>NDED</sub> 23a,27,28a-f	, per ME, g884 10	/22/08 TT		
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be extracted.  retent.  ector: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregn	ancy	23d. Date of delivery	/ Day Year
P.O. Box 68 so that the death certiful greed by the attending the detached for use as	by Phys	1 Yes 2 No 9 Unknown g  Part II. Other significant conditions contr	Unknown		23e. Did toba	acco use contribute to	the cause of death?
cords, P.O.	Completed b		. <u>-</u> .		1 Yes 24a. Was an autopsy		topsy findings available completion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death at Director: After this certificate has been sited in by the funeral director, page 2 should be		25. Was case referred to medical		26.Place of Death (Check	perform 1 Yes 2	ed? death?	
Vita hysicia this cer	o Be	examiner? 1 ✓ Yes 2 No	1:1 Inpatient 2 ER/Outpa	Tother		esidence 6 🗸 Other	: Scene
Sion of Autending Ph death ctor: After tl	ation: T	1 Natural 5 Dending	ta. Date of Injury (Month, Day, Year)  End 9/6/08 Fnd	28c. Injury at Work?  2:36 AM Yes 2 X No	28d. Describe how unk	w injury occurred	
Divising spital or At tours after dare a neral Direct filled in by	Certification:	3 Suicide 6 X Could not be 2	Be. Place of Injury - At home, farm, found in	street, factory, office building, etc.	28f. Location (Street or Town, State CApitol	eet and Number or Ru te)500 B1k • Heights • M	ral Route Number, City Nova Ave.
Division  To the Hospital or Attention 24 hours after death  To the Funeral Director:	Medical	one) 2 Medical Examiner: On th		occurred at the time, date and place, and stigation, in my opinion, death occurred	d due to the cause(s	s) and manner as state	ed.
0.	Σ	29b. Signature and title of certifier		29c. License number		29d. Date signed (Moi	
OGME		30. Name and addy's of perion who comple	, ,	O.C.M.E.		September 6, 20	U8
	ate	Mary G. Ripple MD. Deputy ( 31. Date filed (Month, Day, Year)	Chief Medical Examiner  32. Registrar's Signature	111 Penn Street, Baltimore, M	/iD 21201		
Regist		SEP 2 3 2008 &	Myses S. Again				

08-07126	
Michael Steigerwald	

**Physicia** Medical Exami

> **Funeral** Director

> > any

s 23a or 28a-f show a e notified at once,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

ald	Otate of Maryland / I	Department of	Health and I	<b>All Cop</b> Mental I	ies Are Le	_	008 3042					
	1- For State Registrar	Certificate of	Death		R	eg. No.	100 3042					
n/ er	1. Decedent's Name (First, Middle, Last) Michael George Steigerwald				2. Date of Dea Month Septembe	th Day Year er 18, 2008	3. Time of Death 1455 hrs					
	Facility Name (if not institution, give street and number)     3015 Montebello Terrace	4	4b. City, Town, or Loc Baltimore	cation of Dea		4c. County o	f Death					
	5. Social Security Number 6. Sex 7. Age (	In yrs. last birthday)	If Under 1 Year	If Under 24H	rs. 8. Date of Bir	th (MM/DD/YYYY)	9. Birthplace (State or					
	216-50-4926 1XM 2 F 6	1 Yrs.		Hours M	July 2	0, 1947	Foreign Country) Maryland					
	Usual Residence of Decedent											
JO.	Maryland N/A	Baltimore	on				10d. Inside City Limits 1 X Yes 2 No					
Completed by Funeral Director	3015 Montebello Terrace		10f. Zip Code 21214		0g. Citizen of What	at Country?						
	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 X Yes 2  3 Widowed 4 X Divorced of Fyes, Give Year	No If Ye	s Decedent of Hispar es, specify Cuban, Mo Yes 2 X No s	exican, Puer	Specify Yes or No to Rican, etc.)	14. Race White						
o be	15. Decedent's Education (Specify only highest grade complete		t's Usual Occupation ost of working life, DC			16b. Kind of Bus						
mpiet	Elementary/Secondary (0-12) College (1-4 or 5+)		ai <b>rma</b> n	O NOT use re	etirea)	Heating and airconditioning						
و و	17. Father's Name (First, Middle, Last)  Joseph Steigerwald		18.1		ne (First, Middle, Me e I Purdy	Maiden Surname)						
ٰٰ	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Street an	nd Number o	Rural Route Num	nber, City or Town	, State, Zip Code)					
1	Anna Stiars/Cousin		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 8017 Ridgely Oak Road Baltimore MD 21234									
	20a. Method of Disposition  1 XX Burial 2 Cremation 3 Removal from State	crematory or oth	Place of Disposition (Name of cemetery, crematory or other place)  2 arkwood Cemetery 9/22/08				City or Town, State					
Ш	4 D	j raikwoou U	zanetter y	) 9	144/00	I Daterillo	e Maryland					

Physician /Medical xaminer

Donation 5 Other Specify: 21. Signature of Funeral Service Licensee

failure. List only one cause on each line.

Jer

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit	Sertification: To Be Completed by Physician/Medical Exami
eral Director: After this certificate has filled in by the funeral director, page 2 s	Sertification: To Be Comp

1 🗸 Yes

27. Manner of Death

3 V Suicide

Natural

Accident

Homicide 29a. Certifier 1

29b. Signature and title of certifie

Donna M. Vincenti, MD

SEP

31. Date filed (Month, Day, Year)

1

2

Medical

State

Registrar

2 No

Pending

Could not be

Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

failure. List only one cause or				Between Onset and
Immediate Cause (Final disease	a. Gunshot Wound of Head			Death
or condition resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions,	b			
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):			
events resulting in death) Last	Due to (or as a consequence of):			
	d			
UNPENDED	AMENDED			
IF FEMALE:	23c. If yes, outcome of pregnancy			
23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnar 4 Pregnant at time of death 5 Other (Specify)	ncy	Month D	ay Year
Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
		1 Yes	2 No 3 Prob	ably 4 Unknown
		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of S
25. Was case referred to medical	26.Place of Death (Check o	nly one)	1	
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing	Home 5 Re	sidence 6 V Other:	Scene

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Yes 2 ✔ No

28d. Describe how injury occurred

or Town, State) 3015 Montebello Terrace, Baltimore, MD

28f. Location (Street and Number or Rural Route Number, City

September 19, 2008

29d. Date signed (Month, Day, Year)

Subject shot self

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

22. Name and Address of Facility 1505 Harrord Road Insaltimore Maryland

Approximate Interval

DHMH 17 Rev 1/2001 OCME 2006

**OCME** 

30. Name and address of person who completed cause of death (Item 23a)

28a. Date of Injury FOUND:

(Specify) Single Family Home

Sep 18, 2008

and manner stated

ami -

Assistant Medical Examiner

32 Registrar's Signature

**ORIGINAL** 

28b. Time of Injury

FOUND:

1449 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 17, **Physician** 2008 7:45 P. Mamie I. Steigerwald /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Genesis Perring Parkway Parkville 7. Age (In yrs. last birthday) 96 vre 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 215-10-9549 Months Days Hours Director November 14, 1911 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shore Examiner must be notified at N/A Maryland Baltimore Director 1 Yes 2 No 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a ~ ^ once. 10f. Zip Code 10g. Citizen of What Country? USA 21214 3015 Montebello Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Specify: \$ Specify white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie Wellford Dennis Purdy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Sullivan/Attorney 10 N. Calvert Street Baltimore Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 9/22/08 Baltimore Maryland 21. Signature of Funeral Service Licenses Leonard J. Ruck, Facility 5305 Harford Road Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requiras that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, sate has been signed by the attending physician page 2 should ba datached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnar 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significan th but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe s certificate h death? 1 ☐ Yes 2 2100 1 ☐ Yes 2 No Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deatl 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar

29b. Signature and title of certifier

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8903 HARRIOD PE BALT. 108 2123

0008358

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1 8

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys

/Me Exai

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 12 hours after death.

To the Finneral Director After this certificate has been sinned by the death.

Division or Vital Records, P.O. Box 68760,

	State Registrar		Certificate of Death Reg. No. 2						n a	301.30	
ian	1. Decedent's Name (First, Midd	lle, Last)					2. Date of Month		Day	Year	3. Time of Death
al.	HILDA				SACKS		09		21 2	800	0421 M
er	4a. Facility Name (If not institution						eath	4	4c. County of	of Death	
	UNION MEMORIAL  5. Social Security Number		A (1 )		BAL7	IMORE r   If Under 24 H	lm l o D-4	21.45		N/A	
	218-10-2266 Usual Residence of Decedent	6. Sex 1 □ M 2 💢 F	Age (In yrs. I		Months Days			Day, Yea	18	9. Birthpli Count	ace (State or Foreign ry) NC
	10a. State 10b. County	/	10c. City	, Town or Loca	ation					10	d. Inside City Limits
Director		TIMORE	B	ALTIMOR	E						1 ∐Yes 2 X No
al Dire	10e. Street and Number  8 PONOMA NOF	RTH, APT. 8			10f. Zip Code	21208		10g. 0	Citizen of W	hat Count	ry?
by runeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorceo	If Yes Give	\$? <b>X</b> No	lf '	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 【 No Specify:			pecify Yes or No- pecify Rican, etc.)		14. Race - American Indian, Black, White, etc.  Specify: WHITE	
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			(Give ki	nt's Usual Occu ind of work done O NOT use retir	vorking	16b.	16b. Kind of Business/Industry			
	12 17. Father's Name (First, Middle,			MEDI	CAL INT	ERVIEWER		(First, Middle, Maiden Surname)			
To Be	SAMUEL			COHN	EDA				MEYER		
	19a. Informant's Name/Relations STEPHEN SACK	,						oute Number, City or Town, State, Zip Code) 04, BALTIMORE, MD 21224			
	20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from Sta	20b. PI	ace of Disnosi		ace)	Date	20c.	Location - (	City or Tov	vn, State
	4 Denation 5 ☐ Other (S				CHAIM Name and Addi		/22/2008 SOL LEV				
ä	MIMMAN	Miller		R	ann pei	STERSTON	IN DOAD	_ D1	KECVI	KU3.,	MD 21208
	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	ed the death line.	. Do not enter	the mode of dy Sepsis	ing, such as card	lac or respiratory	arrest,			Approximate Interval Between Onset and Death 24 Hours
er	Sequentially list conditions,	b	as a consequ Chr (	ence on: Ldoil	no lite	masis					I weck.
Examin	Sequentially list conditions, if any, leading to transdict cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	uence of):									
Medical		d									
Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☑ √lo 9 ☐ Unknown	ncy death 3 Ectopic pregnancy eath 5 Other (specify)				23d. Date of delivery Month Day					
ò	Part II. Other significant conditi	iting in the und		23e. Did tobacco use contribute to the cause of death?							
nere									1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onk  a. Was an 24b. Were autopsy findings ava		
Completed							– au	topsy rformed?	pr de	rior to com eath?	pletion of cause of
מ	25. Was case referred to medica examiner?	Hospital:	/		l Ot		eath (Check only	one)			
2	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)										
Certification;	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No										
E L	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Num City or Town, State)							Route Number,			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									ited. the cause(s)		
IVI	29b. Signature and title of certifie	1.	29c. License number  A72 43 8 6 4 (				29d. Date signed (Month, Day, Year)  September 21, 2008  - HOSPITAL, BALTIMERE, 1				
-	30. Name and address of person	who completed cause of	death (Item:	23a) (Type, Pr	int)	Mesano	(A) i	COL	AI	BAC	TIMERE, MD
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 19 2008 **Physician JACOB** DAVID STEINBERG 6:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARMONY HALL ASSISTED LIVING COLUMBIA HOWARD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 02/27/1921 WASHI'MGTON, DC 578-12-0932 87 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f sl incr rust be notified 1 ☐Yes 2 No Director ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 837 MISSION VALLEY LANE 21401 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates: Black, White, et 1 ☐ Never Married 2 ☐ Married WHITE altimore, Maryland 21215-0036 1 □Yes 2 No Specify. Completed by Specify: 3 Nidowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, tre-Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **ENGINEER** SCIENCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT AARON **STEINBERG** LILLIAN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6407 FEW STAR COURT, COLUMBIA, MD SUSAN GIBBS / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MARŸĽÄŇĎŰVĚŤĚŘĂŇŠŰČEM. 09/22/2008 CROWNSVILLE, MD 4 Donation 5 Dother (Specify) 21 Signature of Funer I Service Linear ee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Kemen Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC BLADDER CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to Est as a prinse mence of Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate performed 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 1 Natural 28b. Time of After t Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. neral Director: / investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

Hospital or Attending 124 hours af within 2 To the

Registrar

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

170145

SEP 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICHOLAS KOUTRELAKOS, MD 11065 LITTLE PATUXENT PKWY, COLUMBIA, MD 32. Registrar's Signature

29c. License number

D38509

29d. Date signed (Month, Day, Year)

09/20/2008

08-07135 Cheryl Tucker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eryl Tucker	1-	Sf For State	tate of Maryla	and / Depart <i>Certi</i>	tment of ificate of	Health an <i>Death</i>	d Mentai	Hygien	Reg. N	No. 20	008 3043			
Physician	Re	gistrar Decedent's Name (First, Midd	dle,Last)					2. Date	of Death		3. Time of Death			
cal Examineناوe			cker		_				th Da tember 1	9, 2008	0608 hrs			
(	4	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of						Death	h 4c. County of Death  Montgomery					
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Funeral	5	Social Security Number	6. Sex	7. Age (In yrs. las		Months Day		Min.		Fore	eign			
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after call, on	ğ F		Divorced If Yes, Give Yor Dates:		1	Yes 2 X N		ad of work do	ne 1	Specify: 6b. Kind of Busines				
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MD and 2 shoulth and m 27 is aumatin	L	Betty Huntem	an – siste	er		Meadow.		errace	, Olne	ey, MD 2 20c. Location - City	20832 y or Town, State			
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Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Servi	even H. W	illiams	<sup>22</sup> C	Name and Addre	n Socie	ety of	Mary	land, Incore, MD	21228			
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COF	ηdμ	<u></u>								performed? death?  1 Yes 2 No 1 Yes 2 No				
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	- 6-	and mant	ner stated.	CIRCO HIVOSU						(Month, Day, Year)			
	Ž	29b. Signature and title of certifier  29c. License number  O.C.M.E.								September 2				
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8		30. Name and address of pe		cause of death (Ite ant Medical Ex	em 238) kaminer	111 Penn Si	treet, Baltir	nore, MD	21201					
	<u></u>	Od D to Stand (Marsh Day)		2. Registrar's Sign	100									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Feathh and Mental Hygiene. Important: If iten 27 is marked other thingury or other traumatic event, the Medical Pages.		21. Signature of Funeral Service		λĥ., Wi1]	liams	22	Name and A	ddress <b>1011</b>	of Facility	etv o	f Mary	land	l, Inc.	
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n	-	30. Name and address of person	who c	ompleted cause	of death (Ite	m 23a)							-	
3		Patricia Aronica-Polla				Examiner	111 Pe	nn Si	treet, Ba	altimore, l	MD 21201			
Sta Registra		31. Date filed (Morth, Day Year)	200	32 Redi	strar's Signa	ture								
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s 1 an f Heal ftem 2 other		20a. Method of Disposition	Sici / Boli	20b. F	Place of Dispos				Date	T	tion - City or	•
Page:		1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	Ly Cros	_	1	09/2	4/2008	Balt:	imore,	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If teem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	-		. Name and A			nce Fur	neral :	Servic	e, P.A.
0 8 5 0 5		Imna M	frames	oust		001 Ri		Highwa	ay Bal	timor	e, Mar	yland 21225
		23a Part1. Enter the disease shock, or heart failure.	only one cause on	each line.	n. Do not ente	er the mode of	aying, such	as cardiac	or respiratory a	arrest,	1	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to	(or as a conse	uence of):	re Ite	sach	for	lure	-		
Examiner		Sequentially list conditions	b	Coro	nau	y a	rten	1 0	ises	se		
led sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):	4 22	1	J				
executed in and rial-transit	Exan	that initiated events resulting in death) Last	c	(or as a conseq	uence of):	207(07						
ficate be e physiciar s the buri	ical		d									
ertifica ling ph	Med	iF FEMALE:	00- 16									
eath c attenc for us	cian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	tcome pf pregna birth 2  Feta nant at time of d	l death 3	Ectopic pregr Other (specif				230	d. Date of deli Month	very Day Year
t the d by the	Physician/Medical	1 ☐ Yes 2 M No 9 ☐ Unknown	9□Unkr			, ,						
res tha igned be del	by P	Part ii. Other significant condition	ons contributing to d	leath but not res	ulting in the un	iderlying caus	e given in Par	t i.				the cause of death?
requi	eted		.,							Yes 2		obably 4 Unknown
he lav e has ige 2 s	Completed								24a. Was auto perl	opsy ormed?	prior to death?	topsy findings available completion of cause of
lan: T	a)	25. Was case referred to medical					26. Pla	ice of Deat	1 Yes 1 (Check only	2 No one)	1 □ Yes	2 No
hysic his ce	To B	examiner? 1 Yes 2 No		·	ER/Outpatien			Nursing Ho	me 5 Res	idence 6	XOther (Spec	eify)Son's Home
ding P	ion:	27. Manner of Death  1 Natural 5 □ Pendin investic	9	of Injury oth, Day Year)	28b. Time of Injury	28c.	injury at Work? 1 ☐ Yes 2[	1	28d. Describe	how injury o	occurred	
Atten r deatl ector: by the	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	e of injury - At ho ling, etc. (Specif	ome, farm, stre				28f. Location	(Street and I	Number or Ru	ıral Route Number,
ital or its afte rai Dir led in	Cert									iwn, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 burs after death. Within 24 bursts after death.  To the Euhours after death.  To the Teuneral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burning the funeral director.	edical	29a. Certifier (Check only one)  Certifyin  2 Medical	ng Physician: To the Examiner: On the b and mar	e best of my kno pasis of examina nner stated.	owledge, death ation and/or inv	occurred at to vestigation, in	he time, date my opinion, d	and place, leath occur	and due to the red at the time	e cause(s) ar e, date and p	nd manner as lace, and due	stated. to the cause(s)
Vithii To th	ž	29b. Signature and title of certifier			1.5	29c. Li	cense numbe				signed (Monti	
10		30. Name and address of person	who completed cau	se of death (Item	n 23a) (Type, I	Print)		143				2-2008
lo		L. SEENIVA	SAN, MD,	30	01.5.1	HANOVE	FRSI	-, B	ALTIN	ORE	, MI	), 21225
Sta Registr		31. Date filed (Month, Day, Year) SEP 2 3 2	2008	negisirar s Sigha	Span	Sent .						), 21225

State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	tate of Marylan	•	rtment of F <i>tificate of</i>			ene 200	8 30435
	Diam'r.		Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medio		Ma	ry F. Thomas	S			Septembe		
	Examin	er	4a. Facility Name (If not institution, give stre			**	r Location of Death		4c. County of Do	
	Funeral		Genesis Eldercare S  5. Social Security Number 6. Sex	7. Age (In yrs.		Seve If Under 1 Year	erna Park	8. Date of Birth	Anne A	
	Director			2 <b>⊠</b> F 89	Yrs.	Months Days	Hours Min.	June 21,	1919 M	Birthplace (State or Foreign Country) aryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	jo			Severna					1 ☐ Yes 2X No
	r 28a	Directo	Maryland Anne Aru  10e. Street and Number	nder '	Jevel III	10f. Zip Code		10	g. Citizen of What	Country?
	th with	ralD	24 Truckhouse Road	1		2	1146		U.S.A.	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 23a-f show ent, it at Medical Examiner must be rotified at	Funeral	The market of the control of the con	Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of H f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
336	rs afte	by F		1 ∐Yes 2 <b>X</b> No If Yes, Give Year or Dates:	1	□Yes 2X No	Specify:		Specify:	White
Š	72 hou natura	ted	15. Decedent's Education	on		lent's Usual Occup			6b. Kind of Busine	
21	ithin 7	Completed		College (1-4or 5+)	life. D	OO NOT use retired	•	ing	ъ.	
D	filed w Hygie ther th	S	12th  17. Father's Name (First, Middle, Last)		Ass	istant B	-	e (First, Middle, M.		ent Store
au	e d d	To Be		ank Weiber				erta Casl	,	
Maryland 21215-0036	12 should be th and Mental 7 is marked of traumatic ev	-	19a. Informant's Name/Relationship (Type.	Print)	19b. Mailin	g Address (Street	and Number or Rur	al Route Number,	City or Town, State	e, Zip Code)
	s 1 and 2 if Health item 27 I		Ronald H. Thomas /	son		- 223rd S			, Marylan	
e e	S to # O		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Remo	20b. P oval from State	lace of Dispos emetery, crem	sition (Name of natory or other plac	ce)	Date 2	0c. Location - City	or Town, State
Baltimore,		l d	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee			ge Mem. Name and Addre		2/2008   1	Elkridge,	Mary1and
n	permit. Departr Importa any inj		Dana Maram	www.shi			Go		ral Servi imore, Ma	ce, P.A. ryland 21225
			23a. Part 1. Enter the disease or complications shock, or heart failure. List only one complications are complicated as the complex of the co	ons that caused the death	n. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
mange	Physician		Immediate Cause (Final disease or condition resulting in death)	DEMEN	TIA					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	0710	CAA N.	2 1000	24 4 4	
ı		je	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequ	uence ot):	eric	CARDI	D.	IS BAS	21
	cuted nd ransit	Examiner	that initiated events						4 C/ I	
Ď,	be exe cian a purial-1		resulting in death) Last	Due to (or as a consequ	uence of):					
<b>5876U</b> ,	ificate be executed g physician and as the burial-transit	edical	d							
	± 5, 60	n/Me		f yes, outcome of pregna					23d. Date of	delivery
, a	death cer he attendin ed for use	hysician/M	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnand   Other <i>(specify)</i> _	y 		Month	Day Year
7. O	hat the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributions		ulting in the un	dorlying payon giv	on in Bort I	23a Did tobs	acco uso contributo	to the cause of death?
cords,	requires that the een signed by th nould be detache	d by	PNEDMONIA		inding in the dir	derlying cause giv	en in Faiti.			Probably 4 🗗 Unknown
	s beer	Completed						24a. Was an	24b. Were	autopsy findings available
Ä	The law ate has t page 2 si	mo:						autopsy perform 1 🗆 Yes 2	prior to death	to completion of cause of
VITAI	clan: ertifica ctor, p	Be	25. Was case referred to medical examiner?				26. Place of Deat	(Check only one,		63 2 1110
5	Physi this c al dire	၉	1 ☐ Yes 2 ☐ Mo	1 Inpatient 2 I	ER/Outpatient		4 🗀 Nursing Ho		ce 6 Other (S	pecify)
DIVISION OF	ding th. After funer	Certification:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	8a. Date of Injury (Month, Day, Year)	injury	28c. Injur Worl	yat k? Yes 2 □No	28d. Describe how	injury occurred	
	Atten	ifica	2 □ Puiside 6 □ Could not be	8e. Place of Injury - At ho building, etc. (Specify	me, farm, stre			28f. Location (Stre	et and Number or	Rural Route Number,
5	ital or rs afte al Dir led in	Cer						City or Town,		
	To the Hospital or Attending Physician: The law requires that the divitin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical	29a. Certifier  (Check only one)  1 Certifying Physicia 2 Medical Examiner:	an: To the best of my known on the basis of examination and manner stated.	wledge, death tion and/or inv	occurred at the tirestigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
	To the within To the sompl		29b. Signature and title of certifier			29c. Licens			d. Date signed (Mo	
			> Zollie	MD		DZ	1776	50	W7 EMG	GER 19, 2006
	5		30. Name and address of person who complete Succession for the succession of the suc	eted cause of death (Item	23a) (Type, F	Print)	HANDL	in Si	, BAC	TIMORE
	Sta		31. Date filed (Month, Day, Year)	38. Registrar's Signat		202				
	Registra		SEP 2 3 2008	Blown S.	100	المناع				

	State of Maryland / Department of Health and Mental Hygier	ne
	Reg.  1 Decedent's Name (First Middle Lest)  2 Date of Death  2 Date of Death	No.2008 3 Time of Death 6
Physician	an Dorothy Turner Month	Day Year
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hg. 8. Date of Birth 213-44-7736 1 Months Days Hours Min. April 16,	Birthplace (State or Foreign
and w	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryla a-f sho	37/3	1 <b>XX</b> es 2□No
office death with the Mar in tems 23a or 28a-f shainer must be notified hiner must be rotified Funeral Director	10e. Street and Number 202 North Curley Street 21224	Citizen of What Country? U.S.A
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleating Mental Hygiene. It of Health Mental Hygiene, in them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Majoroced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Majoroced  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  16. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036 ed within 72 hours af ygiene than "natural", or t, the Medical Exami t, the Medical Exami	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  7th  15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired)  HOMEMAKET	Own Home
Maryland 2 nd 2 should be filed th and Mental Hyg 27 is marked other traumatic event, To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maid  Touriso Haccorty	
t, Mary and 2 sho ealth and I n 27 is ma her trauma	19a. Informant's Name/Relationship (Type. Print)  Arthur Turner  19b. Mailing Address (Street and Number or Rural Route Number, City and South East Avenue Balto,	MD 21224
III Post	1 XX urial 2 Cremation 3 Removal from State Crestlawn Memorial 9/26/08	c. Location - City or Town, State  Marriottsville, MD
Balti permit. Departi Importa any Inji once.	21. Signature of Funeral Service Libens.  22. Name and Address of Facility Burgee-Henss-Seitz Funeral He 3631 Falls Road Balto, MD	
Physician /Medical	23a. Part I. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Uniset and Death
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	12 years
68760, ificate be executed g physician and the street burial-transit ts the burial-transit edical Examiner	Due to (or as a consequence of):	
Division or Vital Records, P.O. Box 68760, To the Hospitalior Attending Physician: The law requires that the death certificate be executed within 24 hours fare death.  Within 24 hours fare death.  Within 24 hours fare death.  Within 24 hours fare death.  Within 24 hours fare death.  Within 24 hours fare death.  Within 24 hours fare death.  Within 24 hours fare death.  Within 24 hours fare death.  Within 24 hours fare death.  Within 24 hours fare death.  Wedical Certification: To Be Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery  Month Day Year
rds, P.  juires that right be deta		co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
al Records,  : The law requires t cate has been signe page 2 should be c	24a. Was an autopsy performed 1 Yes 2	
Or Vital Physician: T this certificate ral director, pa	25. Was case referred to medical examiner?	
ig Physi ter this coneral direction. To		
Division or teal that or Attending Physics for deaft. The close of the this ledlin by the funeral diffication: To Certification: To	Total Activities   Total Activ	et and Number or Rural Route Number, state)
Division To the Hospitallor Attenwithin 24 hours for death or to the Funeral Director completely filled in by the Medical Certifical		
To the within To the comple		Date signed (Month, Day, Year) Ptember, 22, 2008
5	30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)	0 0 110
State	TEAMRAT A ADHANOM M.D., Sinai Hospital di 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Baltmore.
State Registrar	ate and a second	
DHMH 17 Rev 1/2001	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 57 PM BENJAMIN NESTER FIELD sertember 20 web /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) JAHNS HOPKINS BAYVIEW MEDKAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months 213-46-0176 Director MARYLAND ULTOBET 27 1945 Usual Residence of Decedent 10a. State 28a-f show 10h. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Evanithment be notified at Director 1 ☐ Yes 2 No MD BALTIMORE WHITE MAIZSH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA 23a BFACH ROAD 11307 21169 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No or items, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify: WHITE ģ If Yes, Give Year or Dates 3 Divorced 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 RESTAU RANT MAINTAUANUE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental WALTON WESTERFIELD EILEEN SEYMORE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a SISTER LINDA WESTER FIELD 11307 BRACH RODD WHITEMAKSH MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If iter
any injury or ott Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BURTOMY WETS PLEUSTE 9/03/2008 4 Donation 5 ☐ Other (Specify) HANDUNZ MARY LAND 21. Signature of Juneral Service Ucensee 22. Name and Address of Facility ANATOMY GIFTS PLEASTRY DR. STE P. HANDUR, MADROTO 7522 WUNNELLEY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBILAL HEMATOMA disease or condition resulting in death) 4 DAYS /Medical Due to (or as a consequence of): CONTRACTOR OF THE PARTY OF THE Examiner 4 1445 SKULL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FLACTUR Examiner Due to (or as a consequence of) be executed and burial-tran Due to (or as a consequence of): 68760, attending physician Physician/Medical Physician: The law requires that the death certificate the as IF FEMALE: nse s 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No ρ Month Day Year 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should I 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 2 □ No 1 □ Yes 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 2 Accident 1 □ Yes SEPTEME 16,248 21 UNLWAUN (PATIENT FOUND DOWN) within 24 hours after deatl To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide STREET Hospital 11301 BEACH ROAD, SALTIMANE, MY Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IETTEMBER 20, 2008 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. CHAMES GALANIS 4940 EASTOWN 21226 AUENUE

State Registrar 31. Date filed (Month, Day, Year) SEP 2 3 2008 32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 5

		For State Registrar		State o	f Marylan		rtment of F tificate of	lealth and l <i>Death</i>		giene Reg. No.	008	30438
Physicia	an	1. Decedent's Nam							2. Date of De Month	Day	Year	3. Time of Death
/Medic	cal		leen	give street and nur			4b. City, Town, o	r Location of Death	Septem		9 2009 County of Death	
		Harbo		latique				imore				<b>I/A</b>
Funeral Director		5. Social Security N 219-54-2	2960	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs. 59	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da DEC 9	1948	9. Birth Cou	place (State or Foreign intry) D.C.
yland Iow at		Usual Residence o 10a. State	10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
e Mar Ba-f sh tified	ctor	MD	N/A	1	В	altimo	re					1 <b>X</b> Yes 2 □ No
with the	Dir	10e. Street and Nu	oris Av	enue			10f. Zip Code <b>2122</b>	5		10g. Citiz	en of What Coւ <b>USA</b>	intry?
death	Funeral Director	11. Marital Status	OLID MV	12. Was Dece	edent Ever in U	l.S. 13. \		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	. 1	4. Race - Ameri Black, White	
72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Marı 3 ☐ Widowed	ried 2 Marrie	Armed Formation 1 Test	ve		I □ Yes 2 <b>X</b> No	Specify:	o i noan, cio.,		Specify:	
2 hour natural ical Ex	ted k		15. Decedent's		utes.	16a. Deced	lent's Usual Occup	pation	Ling	16b. Kin	d of Business/I	ndustry
vithin 7 ine. han "r e Med	Completed	Elementary/Seco		College (*	1-4or 5+)			during most of wor d)	KING	•	Paralei a	-
filed v I Hygie other t ent, th	Be Co	17. Father's Name	(First, Middle, L	ast)		DIS	patcher	18. Mother's Nan	ne (First, Middle,		Trucking Surname)	5
ould be Menta arked atic ev	To B	Robert	A.	Webb				Doris	E.	Ludw	rig	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's N						and Number or Ruer <b>Road</b> ,				p Code) <b>21666</b>
item 2		20a. Method of Dis	sposition			Place of Dispo	sition (Name of natory or other place	1	Date		ation - City or T	
Page tment c tant: If jury or		4 ☐ Donation	5 ☐ Other (Sp	**	Met	tro Cre	matory,	Inc. 9/22			timore,	MD
permit Depar Impor any in once.		21. Signature of Fi	uneral Strict	Sinse H. Wil	liams	22	Cremation 299 Fred	m°Society erick Roa	y of Mar	yland	d, Inc.	21228
Silver a		23a. Part1. Enter t	the disease, or dart failure. List o	complications that comply one cause on e	caused the deat						c, HD	Approximate Interval Between
Physician	r X	Immediate Cause disease or condition	(Final	_a. My	cardio	1 .	arction					Onset and Death
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ecuted and I-transi	Examiner	Cause (Disease or that initiated events resulting in death)	r injury s Last	c. Di c	abetes (or as a conseq		itus ty	pe II				Un Known
icate be executed physician and the burial-transit	edical E			d.	(5. 45 4 55.11554	201100 01/1						
ntificat ng phy e as th		IF FEMALE:										
The law requires that the death certificate be executed itse has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent in the past 12	nonths?	1□Live b	come pf pregna birth 2  Feta nant at time of d	al death 3□	Ectopic pregnancy Other (specify)	/		23	3d. Date of deliving Month	very Day Year
t the d by the ached	hysic	1 ☐ Yes 2 € 9 ☐ Unknown		9□Unkno		Jean JL	Other (specify) _					
res tha igned be det	þ	Part II. Other signi					, ,					the cause of death?
v requi	eted			scale on i	eritonea	1 dialy	5.3 FCV	itonitis	10			bably 4 Unknown
The lav te has age 2 :	Completed	Cholelith	دندی،							rmed?	prior to codeath?	opsy findings available ompletion of cause of
clan: ertifica ector, p	Be C	25. Was case reference	rred to medical		/			26. Place of Dea		2 No ne)	1 ☐ Yes	2□ No
Physic rthis o	၉	1 Yes 2 2 27. Manper of Deat		Hospital: 28a. Date		ER/Outpatien		4 ☐ Nursing H	ome 5 ☐ Resid			ify)
inding ath. r: After re fune	ation	1 ☑ Natural 2 ☐ Accident	5 □ Pending investiga	(Mon	th, Day Year)	Injury	28c. Injur Wor M 1 □	k? Yes 2 □ No	ZDG. Describe i	iow injury	occurred	
l or Atte after des Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	28e. Place	of injury - At ho ng, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (S City or Tox		Number or Ru	ral Route Number,
To the Hospital or Attending Physician: The law within 24 burns after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Medical C	29a. Certifier (Check only one)	1 ☑ Certifying 2 ☐ Medical E	Physician: To the xaminer: On the b	best of my kno asis of examina ner stated,	owledge, death	occurred at the til	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and	title of certifier	and man			29c. Licens	e number		29d. Date	signed (Month	, Day, Year)
				1 1,00	MD		Res	001		Septe	when I	€005 €
10		30. Name and add	ress of person w				Print) Hanove	y stree	+ Bal	timo	R MD	21225
Sta		31. Date filed (Mon	nth, Day, Year)	32. R	egistrar's Signa				<u> </u>			
Registra	ar	SE	P 2 3 20	UO JAMES	But St.	1 de la constante de la consta						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		rtment of F		and Me		giene2 () Reg. No.	08	30439
	Physicia	an	1. Decedent's Name (First, Middle, Last)						Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Taneisha Talee			4b. City, Town, or	. I section o		PPTEME	4c. County	008	8:10 P M
	Examin	er	4a. Facility Name (If not institution, give s		TIMORE	Balti		City		4c. County	or Death	
	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. 25		If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birt (Month, Da	th ly, Year) 1982	Cou	place (State or Foreign htry)
	pu "		Usual Residence of Decedent	10- 0	ty, Town or Loc	- Allen						10d. Inside City Limits
	aryla shov	ř	10a. State 10b. County NA		altimo							1 √ Yes 2 No
	the M	Director	10e. Street and Number			10f. Zip Code				10g. Citizen of V	Vhat Cou	ntry?
	3a or		2910 Garrison	Ave.		2121	.6			USA		•
	filed within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f show ent, it is Model Evan in it in the propility a	Funeral	11. Marital Status	Was Decedent Ever in U     Armed Forces?	.S. 13. W	las Decedent of H Yes, specify Cuba	lispanic Orig	gin? (Speci	fy Yes or No	- 14. Rac	e - Ameri	can Indian,
9	after or ite		1 Married 2 Married Married	1 ⊟Yes 2 No		☐Yes 2 No	Specify:	i, Fuerto rin	oan, etc.)		:: B <b>l</b> ∂	
5-0036	ural",	d by	3 Widowed 4 Divorced	Year or Dates:		A .	ation			16b. Kind of Bu		
-5	n 72 ''nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	I (Give k	ent's Usual Occup tind of work done t O NOT use retired	durina most	t of working		100. Killa of Ba	12111622/11	ldustry
212	withi	mo.	Elementary/Secondary (0-12)  9th	College (1-4or 5+)	Pul	ler	,			Packagi	<b>n</b> g Wa	arehouse
g	al Hyg othe	Be C	17. Father's Name (First, Middle, Last)							Maiden Surnan	ne)	
<u> a</u>	should be f and Mental I s marked ol umatic eve	၉	Gary Weldon				магу	arec	Faul	COII		
altimore, Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite McAcal Evan in must be notified a once.		19a. Informant's Name/Relationship (Typ	,		g Address (Street						•
e,	1 and Health sm 27 ther t	2.3	Margaret Weldon  20a. Method of Disposition			Garris		ve.		20c. Location -		L216
Jor	Pages nent of I int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro	emoval from State		sition (Name of atory or other place					•	
를	nit. Parantme artme prtant injury		4 □ Donation 5 □ Other (Specify)  21. Signatule of Funeral Service License			remator		9-22-		Baltin		, MD
Ba	permit. Departri Importa any inju		> 12 mm	X a Ke		rch Fun 00 Waba						21215
i			23a. Part . Enter the disease, or complice shock, or heart silure. List only on	cations hat caused the deal								Approximate Interval Between
4.	Physician		Immediate Cause (Final disease or condition		HYPOXI	-0	PIRAT		_	URE		Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	uence of):							. 0
	Examiner	L	Sequentially list conditions, b. b.	SEPT		HOCK						19 days
S	ted	Examiner	Sequentiany list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	juence of):							4
0	execu al-trar	xar	that initiated events c. resulting in death) Last	Due to (or as a consec	uence of):						-+	
8760,	cate be executed oblysician and the burial-transit	dical	<b>U</b> d									
9	rtificat ng phy as the	<b>l</b> edì			- C							10 10
30X	eath certific attending p for use as t	an	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	cy			1	te of deliv	very Day Year
O. B	e dea the at ned fo	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify) _				IVIC	אוווו	Day Teal
٣.	uires that the de signed by the a Id be detached i		Part II. Other significant conditions con	tributing to death but not res	sulting in the un	derlying cause giv	en in Part I.		23e. Did t	obacco use con	tribute to	the cause of death?
ds,	uires sign Id be	d by	ADVANCED	AIDS					1 🗆 '	Yes 2 No	3 ☐ Pro	bably 4 Unknown
S	w requir s been s s should	lete	PANUNTOPE	ENIA					24a. Was		Were aut	opsy findings available
Division of Vital Records,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Completed		NAL PAIL	URE				autoj perfo 1 ∐Yes	rmed?	prior to c death? 1 □Yes	ompletion of cause of
ita		Be C	25. Was case referred to medical examiner?				26. Place	of Death (	Check only o			
7	hysic this ce al dire		1 ☐ Yes 2 ☑ No	ospital: Inpatient 2			4 🗆 NU			dence 6 🗆 Oth		ify)
n O	ling P	jon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injui Wor M - 1 □			d. Describe	how injury occur	red	
S	death death ctor: / the i	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, stre		Yes 2□	-	if Location /	Street and Numl	er or Ru	ral Route Number,
<u>&gt;</u>	lor A after Direct	Certification: To	4 Homicide determined	building, etc. (Speci	fy)	ot, tastery, smoo			City or To		701 01 7 tai	as riodic riambon,
	To the Hospital or Attending Physician: whin 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director, it	Medical C		sician: To the best of my knowner: On the basis of examinand manner stated.								
	o the vithin o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	•		29d. Date signe	ed (Month	, Day, Year)
	->- ö		June.	MD		REC	2-00	nn z.		CEPTEM	RCV	19,2008
	$\sim$		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, F		- 0(	UU U		JUI (EI'I	m N	17/1000
	2		AVNI GUPTA	, MD	Sil	WAI HO	SPITI	AL	00	BALTIN	10R	E
	Sta		31. Date filed (Months Pap 72") 3 20	08 32. Tegistrar's Sign	ature	one R.						
	Registr	et l		The second of the second	100	2050 A.J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 57 AM /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death Examiner BALTTMORE IDF MD MEDICAL CIVIR If Under 1 Year | If Under 24 Hrs. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number Funeral 1√ M 2□ F Months Days Hours 59 Director 238-02-5013 07 MD Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In proportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exprincer must be notified at once. Baltimore 1 XYes 2 No Director MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 U.S.A. 1217 West Fayette Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status M☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sinai Hospital 12th grade Material Handler 2vrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wimbish Hattie Roscoe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 Shenika Wimbish-Daughter 32 Stockmill Road Apt 1, Pikesville, Md 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Creamtory Inc 9/24/08 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final HEO-ESOPHAGEAL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inimical cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Dunknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ∐ Yes 2 7 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending n 24 hours after death.

e Funeral Director: Afteletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DEA AU4176435 08 16 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GLEENE BACTIMORE MD 57 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of M	aryland		artment o			Mental Hy	giene Reg. No?	0.8	30441
	Physici	an	Decedent's Name (First, Middle, L.)	Anne Ma	v Will					2. Date of De Month	Lyan top	Year 2008	3. Time of Death
-	/Medic Examir		4a. Facility Name (If not institution, g				4b. City, Tov	wn, or L	ocation of Death			ty of Death	12:43 A
1	Exami	lei	551 First A						hicum		Anr	ie Aru	.ndel
	Funeral Director				je <i>(In yrs. l</i> a 75	st birthday) Yrs.	If Under 1 Y Months D	ear ays	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/06/	th ay, <i>Year</i> ) 1932	9. Birthp	olace (State or Foreign ntry) Tand
	laryland show	o.	Usual Residence of Decedent  10a. State 10b. County	Arundel		Town or Lo						1	1 ☐ Yes 2 ☐ No
	ath with the Marylar s 23a or 28a-f show ust be natified	Funeral Director	10e. Street and Number		Д.		10f. Zip Co				10g. Citizen o		ntry?
	ath w	ral	551 First Avenu	T				210			U.S		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventinar must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 X If Yes, Give Year or Dates:			Nas Decedent fYes, specify I □Yes 2 <b>X</b>		panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Spec	ace - Americ ack, White, sify: Wh	
21215-0036	thin 72 ho ne. nan "natur Medical I	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	ducation rade completed) College (1-4or s	5+)	(Give life. i		lone du etired)	ion ring most of wor	king	16b. Kind of		dustry
nd 21	be filed wi tal Hygien d other th event, I've	Be Con	12th 17. Father's Name (First, Middle, Las	t)		Ноп	emaker		8. Mother's Nan			Home	
yla,	should be fi and Mental I s marked of umatic eve	မ	(Not avail		Lang					Rapp			
, Maryland	1 and 2 sh Health and ern 27 is n other traun		19a. Informant's Name/Relationship Gail Wilhide /				•		ue Apt.		thicum,	Mary]	land 21090
Baltimore,	Pa ant:		20a. Method of Disposition 1 ☐ Burial 2 【X*Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		_ cei	metery, cřen	sition (Name of natory or other Cremato	r place)	09/2	Date 24/2008	20c. Location Baltin	-	own, State Maryland
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	ensee .	nhi.				of Facility Go ie Highv				, P.A. land 21225
	Physician /Medical		23a. Part1. Enter the disease cor shock, or heart failure of only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	ne. eno	carc	er the mode o		^	137	arrest,	4	Approximate Interval Between Onset and Death
8760,	cate be executed by physician and the burial-transit and	dical Examiner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as									
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal o	death 3	Ectopic preg				4	Date of deliver	ery Day Year
ds, P.	signed by	5	Part II. Other significant conditions	contributing to death b	ut not result	ting in the ur	nderlying caus	e given	in Part I.	23e. Did t		ntribute to t	he cause of death?
Records,	<b>hyslcian:</b> The law requir his certificate has been s I director, page 2 should	Completed								24a. Was auto perfo	psy prmed2	prior to co death?	opsy findings available impletion of cause of
tal	an: T tificat or, pa		25. Was case referred to medical						26. Place of Dea	1 ☐ Yes	2 No	1 🗆 Yes	2 No
of Vital	Physician: r this certificaral director, p	o Be	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpati	ent 2□E	R/Outpatier	t 3 🗆 DOA	Other			idence 6 🗆 C	ther (Specia	fv)
ion of	<b>ding P</b> h. After t funera	Certification: To	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da	ıry 2	28b. Time of Injury	28c.	Injury a Work? 1 🗆 Ye			how injury occi		57
Division	Direct of	Sertific	3 Suicide 6 Could not I determined	28e. Place of Inj	ury - At hom c. (Specify)	ne, farm, stre	eet, factory, of	fice		28f. Location ( City or To		nber or Rura	al Route Number,
	Hos Hun Tely	Medical (	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best miner: On the basis of and manner st	of examination	ledge, death on and/or in	occurred at tweetigation, in	the time	e, date and place nion, death occu	e, and due to the irred at the time,	e cause(s) and , date and place	manner as s e, and due to	stated. o the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	le N	lD			icense r	6354		29d. Date sign	ed (Month,	Day, Year)
_	4		30. Name and address of person who E.W. COLE St	AGNES	900	) CA	Print)		BAL	TIMOR	E M.	0 2	1229
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	re Aven	1						

DHMH 17 Rev 1/2001

Registrar

08-06963 William Wedemeyer, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 30442

	1- For State Registrar	C	ertificate of	Death			g. No.			
Physician/ Medical Examiner	1. Decedent's Name (First, Middle	William E.	Wedemeye	r, Jr.		2. Date of Death Month Day September 11, 2008  3. Time of Death 2335 hrs				
	4a. Facility Name (if not institution University Hospital	, give street and number)	4	b. City, Town, or Li Baltimore	ocation of Deat	n'	4c. County of De	eath		
Funeral Director		6. Sex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mit		th(MM/DD/YYYY) 9. 5/1950	Birthplace (State or Foreign Country) Maryland		
	217 52 8497 Usual Residence of Decedent							10d. Inside City Limits		
w any	10a. State 10b. County		ity, Town or Location Baltimo:					1 Yes 2 X No		
Aaryfand 28a-f show 1 at once	Maryland Anno	e Arundel	Daitino.	10f. Zip Code		1	0g. Citizen of What 0	Country?		
th the Maryland 23a or 28a-f sho notified at once	5705 Park Roa	ad		212	25		U.S.A			
with the benoti	11. Marital Status	12. Was Decedent Ever in	13. Was	Decedent of Hisp es, specify Cuban,	anic Origin? ( §	Specify Yes or No	14. Race - A White, et	merican Indian, Black, c.		
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland benet of Health and Mental Hygiene.  Fant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Never Married 2 XMa 3 Widowed 4 Divo	rried 1 Yes 2 X No	1	Yes 2 X No	specify:		Specify:	White		
hours after a stanting the sample of the sam	15. Decedent's Education (Spec	ify only highest grade completed	) 16a. Deceden during mo	t's Usual Occupationst of working life.	on (Give kind of DO NOT use re	work done tired)	16b. Kind of Busine	ess/Industry		
5-0036 ed within 72 hour lygiene. other than "nature Medical Exan Completed	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	Ow	ner			Blading			
21215-0036 Muld be filed within 77 Mental Hygiene. marked other than c event, the Medical	17. Father's Name (First, Middle,			1		ne (First, Middle, Dorothy	Maiden Surname)			
2121 uld be fil Mental I marked c event,		sworth Wedemeye	er, Sr.	Address (Street	and Number o	r Rural Route Nu	mber, City or Town, S	State, Zip Code)		
MD 21 d 2 should the and Me n 27 is ma aumatic ev	Adele Wedeme	yer / Wife	5705	Park Roa	ad B	altimore	e, Marylan	d 21225		
re, MC s. 1 and 2 sl of Health ar If item 27 Iner traums	20a. Method of Disposition  1 X Burial 2 Cremation	2 Romoval from State	b. Place of Dispos crematory or oti	ner place)		Date	20c. Location - Ci			
imo Pages ment of ant: I	4 Donation 5 Other Sp		Cedar Hil		-			re, Maryland vice, F.A.		
Baltimore, permit. Pages I at Department of Het Important: If ite	21. Signature of Funeral Service	1000 Daldage	22. N 40	lame and Address	orracility ( lie High	once ru nway Ba	neral ser 1timore, N	Maryland 21225		
Physician	23a. Part I. Enter the disease, or	complications that caused the de								
/Medical xaminer	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	0 -11	s of Rad	iofreque trial fi	ncy abl	ation o: ion	the hear	Death		
	Sequentially list conditions,	b								
in a single	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (of as a consequent	os of). 							
ted Insit	events resulting in death) Last	Due to (or as a consequent								
3760, ficate be executed g physician and street transit	Xunpended	AMENDED 23a,F	PII,27,28	a-f, per	ME, g88	4 10/31	/08 TT			
760, ficate be g physic the bur	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		etal death 3	Ectopic preg	nancy	23d. Date of de Month	elivery Day Year		
certifications use as	past 12 months?	4 Pregnant at time	of death 5 O	etal death 3 ther (Specify)		, namely				
tal Records, P.O. Box 68.  cian: The law requires that the death certifi certificate has been signed by the attending ector, page 2 should be detached for use as i	Part II. Other significant condit	3 Olivioni	at specified in the	undorlying cause	riven in Part I	23e. Dio	tobacco use contribu	ute to the cause of death?		
P.O. s that the gned by e detach	Il Humantangi	ve atherosclero						Probably 4 Unknown		
Records, I The law requires ficate has been sign, spage 2 should be	<u> </u>	ve deficiosoficia	7010 0414			24a. Wa	s an 24b. We	ere autopsy findings available or to completion of cause of		
e law r te has b						<b>_</b>  pei	formed? de	ath? ✔ Yes 2 No		
cian: The certifical rector, pa					e of Death (Che					
F Vita	1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien		Other Nu	rsing Home 5	Residence 6	Other:		
in of oding Pt. h.: After e funeral	27. Manner of Death  1 Natural 5 Pen	28a. Date of Injury (Month, Day, Year) ding 9/11/2008	2335 h		Yes 2 X No		and live			
Division of Vital Records, P.O. spiral or attending Physician: The law requires that thours after death.  Incred Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac	2X Accident Inve	estigation 28e. Place of Injury -	At home, farm, stre		building, etc.	28f. Location	(Street and Number	or Rural Route Number, City		
Div pital o ours aft ceral D filled j	4 Homicide	ermined (Specify) HOS	oital			Hospit	a1			
	_ Zad. Certifier 4	hysician: To the best of my kno aminer: On the basis of examinat	wledge, death occu ion and/or investiga	urred at the time, d ation, in my opinion	ate and place, n, death occurre	and due to the ca ed at the time, da	ause(s) and manner a ite and place, and du	e to the cause(s)		
To To con	29b. Signature and title of certifi	and manner stated.	0	29c. Licens				d (Month, Day, Year)		
	ln	u ans	( 7 )	0.C	.M.E.		September	12, 2000		
Jor by	30. Name and address of person Russell Alexander MI	.66	xaminer 11	1 Penn Street	, Baltimore,	MD 21201				
Sta		2008 32 Registrar's Si	gnature	200						
Registr	Committee of the commit		0 1				OCME			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Donald Yancey 3:39a. 09 17 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Columbia Lorien Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, O 9 17) Year) 31 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Social Security Number 1 X M 2 □ F 578-46-8560 Director 77 GA Usual Residence of Decedent 10a. State 10c. Cify, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be retiffed at Director 1 ☐ Yes 2√☐ No MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21076 U.S.A. 7607 Harmans Road by Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. filed within 72 hours after 1 Mes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced 'natural' Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "ns any injury or other traumatic event, Ite Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Westinghouse 4yrs+ 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Mary Allen ပ္ Lyman L. Yancy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5564 Sheperdess Court, Columbia, Md 21045 Ronald Yancey-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Glen Haven Memorial 9/25/08 Glen Burnie, Md 4 ☐ Donation 5 ☐ Other (Specify) natur of Funeral Service License 22. Name and Address of Facility
March F/h West 23a. Purt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or have distinct. Covered failure. List only one gause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death CARDIOVASCULAR DISEASE Immediate Cause (F disease or condition resulting in death) mediate Cause (Final HTHEROCC LEROTIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Division of Vital 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 virsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO After this of funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number D0060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pegistrar's Signature RIVER NECK ROAD #109 BALTIMORE KHETERPAL PANKAT 31. Date filed (Month, Day, Year) 32. State Soul Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of	Maryland		artment of F rtificate of		and Menta	l Hygien Reg. N	2000	30444
	District 1		1. Decedent's Name (First, Middle,	Last)					2. Date	of Death	<u> </u>	3. Time of Death
	Physici /Medio		Carol 0.	Arlan						ember 8	yay Year , 2008	12:15 P M
	Examin	er	4a. Facility Name (If not institution,	give street and num	nber)		4b. City, Town, o	r Location of	f Death	4	c. County of Dea	th
Mark <sup>2</sup>			8102 Hampden Lane 5. Social Security Number	S. Sex	7. Age (In yrs. la	ot hirthday)	Bethes If Under 1 Year		A Hrs.   P. Dote	of Birth	Montgomer	y thplace (State or Foreign
Н	Funeral Director		068-22-0190	1 □ M 2 🖾 F	83	Yrs.	Months Days	Hours	Min. (Moi	of Birth oth, Day, Yea 7 20, 19		ountry)  New York
	ס		Usual Residence of Decedent						July	20, 17		TOW TOTAL
	arylar show	<u>_</u>	10a. State 10b. County		10c. City	Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	Maryland Mont	gomery		<del></del> .	10f. Zip Code	Bethes	sda ————	100.0	Citizen of What Co	
	3a or		8102 Hampden Lane				Toi. Zip code	20814	<u>.</u>	Tog. C	U.S.	•
	death ms 2	Funeral	11. Marital Status		dent Ever in U.S	13. \	Vas Decedent of H f Yes, specity Cuba			or No-	14. Race - Am	erican Indian,
Baltimore, Maryland 21215-0036	of 2 should be filed within 72 hours after death with the Maryland than deneith Hygiene.  27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventings the notified at	ğ	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced	Armed Ford  d 1 □Yes 1  If Yes, Given Year or Da	2 ☑ No e		tYes, specity Cuba	an, Mexican, Specify:	Puerto Rican, e	tc.)	Black, Whit Specify:	e, etc. white
2-0	72 hor	Completed	15. Decedent's (Specify only highest	Education		16a. Deced	dent's Usual Occup	ation	of working	16b.	Kind of Business	/Industry
21	rithin ne. <b>han</b> "l	mple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L	kind of work done OO NOT use retired		or working			
2	iled w Hygie ther ti nt, th	Co	17. Father's Name (First, Middle, La	Z zet)			Merchandis		's Name (First, I	Aiddle Maide		ng Industry
ä	d be f ental l ced of c eve	Be c	_	Lonel Osmans	ek v		:	18. Motrier	,	na Saltzi	,	
<u>_</u>	shoul ind M imari umati	언	19a. Informant's Name/Relationship		, ky	19b. Mailin	g Address (Street	and Number				Zip Code)
Ž.	and 2 lealth a m 27 is		Margi Kramer - I	aughter			Hampden La					
ore.	of it is		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3	□ Domous lifes as C	20b. Pla	ace of Dispos metery, crem	sition (Name of natory or other place	ce)	Date	20c.	Location - City or	Town, State
֝֞֞֟֞֝֞֝֞֝֟֝֟	Pag Iment Iant: I		4 □ Donation 5 □ Other (Spe		late	en of Re	emembrance	Cem. 9	9/9/2008		ksburg, Ma	
Ra	permit. Page Department of Important: If any injury or once.		21. Sign rure of Juneral Service Li	n. Ja	ar.	11	Name and Addre	ss of Facility mpshire	Hines-Rin Avenue,	aldi Fu Silver S	neral Home Spring, MD	e, Inc. 20904
· P	hysician		23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final			Do not ente	er the mode of dyir	ng, such as c	ardiac or respira	itory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		epatoma oras a conseque	ence of):						18 months
	xaminer		Sequentially list conditions	<sub>b.</sub> He	atitis							
7	is is	ine	Sequentially list conditions, if any, leading to immediate Eric Uncertains Cause (Disease or injury that initiated events	Due to (o	r as a conseque	ence of):						
	arecur al-tran	Examiner	that initiated events resulting in death) Last	c	r as a conseque	ence of):						
6/60,	cate be executed physician and the burial-transit	dical E		d	·	ŕ						
20	ng phy as th	ledi		u.							-	
Othe Hosnital or Attending Physician The Jan requires that the death continu	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending toompletely filled in by the funeral director, page 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		rth 2□ Fetal o ant at time of de	death 3	Ectopic pregnanc Other (specify)	у		_	23d. Date of de Month	livery Day Year
7,6	med be deta	by P	Part II. Other significant condition:	s contributing to dea	ith but not result	ing in the un	derlying cause give	en in Part I.	23e	Did tobacco	use contribute to	the cause of death?
cords	en sig									1 ☐ Yes 2	2 □ No 3 □ P	robably 4 🛭 Unknown
	ite has be	Completed							_   _	. Was an autopsy performed? Yes 2 AN	prior to	stopsy findings available completion of cause of
2 5	artifice stor, p	BeC	25. Was case referred to medical examiner?					26. Place o	of Death (Check		o  1∐Yes	2 □ No
> i	this ce	၉	1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ In	patient 2 ☐ E	·	3 □ DOA Othe	er: 4 🗆 Nurs	sing Home 5 X	Residence	6 ☐ Other (Spe	cify)
	ath. r: After t e funera	ation:	27. Manner of Death 1 △ Natural 5 ☐ Pending 2 ☐ Accident investigat		Injury , Day, Year)	8b. Time of Injury	28c. Injuri Work M 1 🗆	yat (? Yes 2 ∐ No		cribe how inju	iry occurred	
	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine	ad 28e. Place o	f Injury - At hom g, etc. <i>(Specify)</i>	ie, farm, stre	et, factory, office	43.	28f. Loca City	tion <i>(Str</i> eet a or Town, Stat	nd Number or Ru e)	ural Route Number,
Hospi	n 24 hour ne Funera	edical (	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical Ex	Physician: To the bas aminer: On the bas and manne	sis of examination	ledge, death on and/or inv	occurred at the tir estigation, in my o	ne, date and pinion, death	I place, and due n occurred at the	to the cause( time, date ar	s) and manner and place, and due	s stated. to the cause(s)
Tot	With:	Ž	29b. Signature and title of celeffier	el m			29c. License	number D002360	00		ate signed (Mont	
			30. Name and address of person where Bruce Kressel, M.D.									2000
	Stat	е	31. Date filed (Month, Day, Year)	₩. Reg	gistrar's Signatu	re 🚜		, onde	, milytall			
21114	Registra		SEP 0 9 20	08	w B.	19004						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 854 Month Day Edith Mae Alger 2008 September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fahrney-Keedy Home & Village Boonsboro Washington 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 X F 220-16-1714 FEB 16 1924 Brunswick, MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MD 1 ☐ Yes 2 ☑ No Washington Knoxville 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 1739 Rohrersville Road 21758 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Newberry's Store Elementary/Secondary (0-12) College (1-4or 5+) Clerk Brunswick, MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Edward Devine Sarah Margaret Mock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Kay Tritapoe, Daughter 1739 Rohrersville Road, Knoxville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Bymjal 2 ☐ Cremation 3 ☐ Removal from State Brownsville Heights & ☐ Other (Specify) 19/8/08 4 □ Donation Brownsville, MD 21. Si rayre of Pupera Service Leaf ser Manager Barbara A. Williams, Owner 22. Name and Address of Facility
John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cevelrovoscalar Due to (or as a consequence of): Demention Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗺 No Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Solution Home 5 Residence 6 Other (Specify) 1 ⊟Yes 21⊈ No 1 | Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician/Medical Completed by

Examiner burial-tra Be Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

Director

Funeral

Completed by

Be

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I

**Physician** 

/Medical

Examiner

physician

death certificate be executed

funeral director, pege 2 should Vital After this To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by

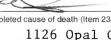
31. Date filed (Month,

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Dr. Khalid Waseem



29c. License number DI 5 153

Eccrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29d. Date signed (Month, Day, Year) 8005-70-80

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1126 Opal Court, Hagerstown, MD 21740

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 ar SEPT. **Physician** CAROLYN DENISE BRIDGES 3 9:47 AM /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY Casey House Rockville 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 3 **Funeral** Year Months Days Hours Min. ,1961 122-52-2514 47 July Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exactinar must be notified at Director MD Montgomery Montgomery Village ty⊈Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20115 Welbeck Terrace 20886 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 72 hours after 1XX Yes 2 If Yes, Give 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: þ 79 - 83Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Montq. Co Elementary/Secondary (0-12) College (1-4or 5+) 12th Office Service Coordinator Police Dept permit. Pages 1 and 2 should be filed very Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, Ill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Luter 2 Mary Moye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type. Print) Roy Bridges (Husband) 20115 Welbeck Terr, Montgomery Village, MD 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State MD Veterans Cem 9/10/08 Cheltenham, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signatury of Funeral Service Live 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Seizures Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Hypertension burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 5 Other (specify) detached 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ge e 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed 2 No 1 □ Yes 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other:  ${}_4\square$  Nursing Home  ${}_5\square$  Residence  ${}_6\cancel{\cancel{2}}$ Other (Specify) Hospice 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 20063748 lehou, ) J. Koud 9/3/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. University Pkwy, Baltimore, MD Jocelyne Kouatchou, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 0 9 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 7, 2008 Physician George Lewis Barquist 5:00 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Days 287-09-3487 Jan, 12, 1913 Iowa Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 419 Russell Avenue, #418 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1941-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No 1955 Specify: ρ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Materiels Manager Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Lawrence Barquist Josephine Ogden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol E. Barquist (Wife) 419 Russell Avenue, #418, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State September 8, 2008 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Fun and Service 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line.

Immediate Couse (Final disease or Indition and Indian and Indian and Indian and Indian and Indian and Indian and Indian and Indian and Indian and Indian and Indian Approximate Interval Between Onset and Death Immediate C se (Final disease dition resulting in death) Lucks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause Error Urcerthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 10 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Many fer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ∏ Yes 2 ∏ No 2 Accident 3 Suicide

Examiner burial-transi and physician P.O. Box 68760 that the death certificate be the attending nse ed by the a signed b Division or Vital Records, certificate has page 2 s

**Physician** 

/Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Physician/Medical à Completed Be 2 Certification:

director. After this funeral ne Hospital or Attending Pin 24 hours after death. filled in by

Medical

To the I within 24

4 Homicide

(Check only one)

29a. Certifier

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

and manner stated.

29c. License number DO4/15 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ RUSSELLA (CA) UE L. RUBERT BIRSCHBACH, MA, CHITHELSBUKE, MIN) L. RUBERT BIRSCHBACH, MM; 31. Date filed (Month, Day, Year)

State Registrar

SEP 0 9 2008



			For State Registrar	State	of Maryla		artment of I <i>rtificate of</i>		d Mental Hy	giene <sub>Reg. No.</sub> 20 (	08 30448
	Physicia		Decedent's Name (First, Middle,  Joan M. Baker	Last)					2. Date of De Month Septem		3. Time of Death 7:35 p M
	/Medic		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town, o	or Location of De		4c. County of	
	Examin	er	Renaissance Gardens			lage		lver Spr		Prince	George's
	Funeral		5. Social Security Number 6 059-28-4105	. Sex 1 □ M 2 1 F	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days		in. (Month, Da	th ay, Year) 17, 1933	9. Birthplace (State or Foreign Country) Illinois
	Director		Usual Residence of Decedent		/4				bept.	17, 1554	111111015
	/land		10a. State 10b. County		10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary 3-f st	ţo	Maryland Montg	omery		Ke	nsington				1 ☐ Yes 21K No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?
	th wit	ä	3809 Archer P	lace			2089	5		USA	
ð	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Nadical Errei, har nutt be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed F d 1 □ Yes If Yes, G	2 🔀 No Bive	1 U.S. 13.	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No	oan, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)		American Indian, White, etc. <b>hite</b>
15-0036	72 hours natural" dical Ex	Completed b	3 🛣 Widowed 4 ☐ Divorced  15. Decedent's (Specify only highest	Year or Education grade completed		1 (Give	edent's Usual Occu kind of work done	during most of v	working	16b. Kind of Busin	ness/Industry
2	ithin han "	d d	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use retire	ed)			-1 C
N.	filed w Hygier Sther th			4			Analyst	10 Methods N	Jama /First Middle	Heder , Maiden Surname)	al Government
Maryland	es 1 and 2 should be fil of Health and Mental H f Item 27 Is marked ott r other traumatic even	To Be	17. Father's Name (First, Middle, La John O'Hora	ist)					ne Madal	·	
ar y	shou and N mar	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mail	ing Address (Stree	t and Number or	Rural Route Numb	er, City or Town, Si	tate, Zip Code)
_	nd 2 alth a 27 Is ir trai		Teresa Baker/D	aughter			3809 Arc	her Plac	e. Kensi	ngton, MD	20895
Baltimore,	Pages 1 and 2 nent of Health ant: If Item 27 I ary or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		n State I		osition (Name of ematory or other places	sce) Se	Date 13, 2008	20c. Location - Ci	ity or Town, State
	artme artme ortani Injury		4 □ Donation 5 □ Other (Special Service Li	_	- 10.5		22. Name and Addr		2008	Germant	own, Maryland
g B	permit. Pages Department of Important: If It any Injury or of		1 Cinches	Hol	e	-	500 Univ	ersity E	Blvd. W.,		nc. pring, MD 2090 Approximate
	Physician	1	23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on	each line.		Failure	ing, such as can	diac or respiratory a	irrest,	Interval Between Onset and Death One Week
	/Medical		resulting in death)	- a	o (or as a cons						
	Examiner		Sequentially list conditions	<sub>b.</sub> Bra	dycard	ia					
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a cons	sequence of):					
60,	ficate be executed physician and s the burial-transit	al Examine	Cause (Disease or injury that initiated events resulting in death) Last	c Due to	o (or as a cons	sequence of):					
9/8	icate phys	dical	·	d							
. Box 6	death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live	outcome of pre e birth 2 I F egnant at time	etal death 3	☐ Ectopic pregnar ☐ Other (specify)			23d. Date Mont	of delivery th Day Year
л О	at the by the tache	hy	9 🗌 Unknown								
Records,	law requires that the de as been signed by the 2 should be detached	b	Part II. Other significant condition	s contributing to	death but not	resulting in the	underlying cause g	iven in Part I.			oute to the cause of death?  B Probably 4 Unknown
ပ္သ	s bee	Completed							24a. Was		ere autopsy findings available ior to completion of cause of
$\mathbf{r}$	sician: The law certificate has birector, page 2 s	E O							— auto	ormed? de	eath? □Yes 2□No
	an: a tiffica tor, p	a	25. Was case referred to medical	T				26. Place of	Death (Check only		2700 212110
	yslci is cel direc	0 B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1	] Inpatient 2	2 ☐ ER/Outpatie	ent 3 DOA	ther: 4 🔀 Nursir	ng Home 5 ☐ Res	idence 6 □Other	r (Specify)
0	ding Phys. h. After this of funeral dire	Ë	27. Manner of Death	28a. Dat	te of Injury onth, Day, Yea	28b. Time	of 28c. Inj	ury at	28d. Describe	how injury occurred	d
0	Attending Physician: or death. ector: After this certific by the funeral director,	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	ation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,		⊒Yes 2 □No			
_	- 4.4	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flat	ce of Injury - A Iding, etc. <i>(Sp</i>	At home, farm, s ecify)	treet, factory, office		28f. Location City or To	(Street and Number wn, State)	r or Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (		xaminer: On the						e cause(s) and mar , date and place, ar	nner as stated. nd due to the cause(s)
	To th within To th comp	Me	29b. Signature and time of Certifier	////		1	29c. Lice	nse number		_	(Month, Day, Year)
	10		>/Mulla	Mu	W.	2		D24093		Septembe	r 8, 2008
	15		30. Name and address of person w	no completed ca	use of death	(Item 23a) (Type	e, Print)				
			Mark Parkhurst	-	-73		ld Road,	Silver	Spring,	MD 20904	
	Sta		31. Date filed (Months Day) Year)	9 2008 32.	Registrar's S	ignature	Cores 1				

08-06960	
Dwayne Batson	

2008 30449

wayne Batson	1-	State of Maryland / Departm For State Certific	ent of	Health and	Mental Hy		N	
Physician/	<u>Re</u>	peristrar Decedent's Name (First, Middle,Last)	-			2. Date of Death		3. Time of Death
/ledical Examine	r	Dwayne Thirston Bo a. Facility Name (if not institution, give street and number)	2+50	N, Sr.		Month September		1642 hrs
1	48		. 41	o. City, Town, or Lo	ocation of Death		4c. County of Dea Dorchester	ath
	Ļ	Dorchester Hospital  Social Security Number 6. Sex 7. Age (In.yrs. last bir	thday)	Cambridge  If Under 1 Year	If Under 24Hrs.	8. Date of Birt		Birthplace (State or Foreign
Funeral Director	ı		Yrs.	Months Days	Hours Min.			Country)
Billecter	_	113 - 98 - 5336   1V M 2 F   36	115.			mayo	0,1110111	/
au .	_	0a. State 10b. County 10c. City, Town				1 7 1		10d. Inside City Limits 1 Yes 2 No
Maryland Asa-f show d at once.	;	MD. Dorchester Ca	Mb	ridge		122	Oir of Minor Co	
the Maryland as or 28a-f sh liffled at once	1	0e. Street and Number	ľ	Tur. Zip Lode	13	10	ng. Citizen of What Co	
after death with the Maryland al., or items 23a or 28a-f she iner must be notified at once over Funeral Director		1 Marital Status 12. Was Decedent Ever in U.S.	13 Was	216 Decedent of Hisp		ecify Yes or No-	74. Race - Am	erican Indian, Black,
or items 23.	ין ו	1 Never Married 2 Married Armed Forces?	If Ye	es, specify Cuban,	Mexican, Puerto	Rican, etc.)	White, etc	
fler de		3 Widowed 4 Divorced If Yes, Give Yeer		Yes 2 No			Specify: B	
natural" xamine		To: Docodonic Education (Epithy) they have	. Decedent	's Usual Occupations of working life. I	on (Give kind of w DO NOT use retir	rork done red)	16b. Kind of Busines	,
0036 within 72 hours giene. her than "natur Medical Exam	2	Elementary/Secondary (0-12) College (1-4 or 5+)	Grou	p Leader			Cookend	Industry
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan	<u> </u>	17. Father's Name (First, Middle, Last)		1	8.Mother's Name			Treessing
21215-0036  21215-0036  Mental Hygiene. marked other than "natural cevent, the Medical Examin		Dwight Batson			Brev	rda 1	Cephas nber, ity or Town, Si	
2 le m de 2	<b>5</b> 1		9b. Mailing	Address (Street	and Number or F	Rural Route Nur	nber, fity or Town, Si	tate, Zip Code)
and 2 sho lealth and tem 27 is traumati	-	Pelynda Palmer Batson 1 20a. Method of Disposition 20b. Place	of Dispos	ition (Name of cem	reer Ca/ netery,	Date Date	20c. Location - City	or Town, State
altimore, mit. Pages I ar epartment of He portant: If ite		1 Burial 2 Cremation 3 Removal from State crem	atory or oth	ner place)	9	120/08	F 0/ 100	west MD.
it. Partiment rithent	-	4 Donation 5 Other Specify: L.N., 4 21. Signature of Funeral Service Licensee	Jarke 22. N	lame and Address	of Facility	1-4-01-4	0 A.	They wo
Balt permit Departi Import injury	1	Janelle C. Henry	14	enry Fu	hington	Sty C.	ambridge	MD, 21613
Physician	1	23al Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter ti	te mode or dying,	Such assertiac o	1 103pilatory ari	est, shock, or heart	Between Onset and
/ /Medical xaminer		Immediate Cause (Final disease a. Anomalous Origi	n Rig	ght Coron	ary Arte	ery		Death
	П	or condition resulting in death)  Due to (or as a consequence of):						
3		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						
led nisit	Ē	C. Disease or injury that initiated events resulting in death) Last						
executed an and al - transit	<u>֡</u>	d.  X UNPENDED X AMENDED 1,23a, pt	<u> </u>	27	16a b	nor fh	~99/ 10-2	0_08 ===================================
be be	edical			Z/ per m		per in	23d. Date of del	
		IF FEMALE: 23c. If yes, outcome of pregnant in the 1 Live birth	-	etal death 3	Ectopic pregn	ancy	Month	Day Year
	Physician/m	past 12 months?  4 Pregnant at time of death 1 Yes 2 No 9 Unknown a Unknown	5 O	ther (Specify)			İ	
	ڄ	Part II. Other significant conditions contributing to death but not result	ting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use contribut	e to the cause of death?
ires that signed b	2	Cardiomegaly with Biventricula				t 1 Ye	es 2 No 3	Probably 4 Unknown
Division of Vital Records, P.O. Box ha or Attending Physician: The law requires that the death rs after death.  The Invector After this certificate has been signed by the attent in by the funeral director, page 2 should be detached for a led in by the funeral director, page 2.	Completed	Ventricular Hypertrophy				24a. Was		re autopsy findings available r to completion of cause of
of Vital Records ing Physician: The law required the this certificate has been uneral director, page 2 should	립	venericalar nyporokopny		<del></del>		perf	ormed? dea	th? Yes 2 No
I Re		25. Was case referred to medical			of Death (Check	only one)		
Vita ysicia this ce direct	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER	/Outpatien	( 3 <u>DOA</u>		ng Home 5		Other:
ing Pt After funeral	٦	(Month, Day, Year)	b. Time of		ry at Work? Yes 2 No	28d. Describe	how injury occurred	
ivision or Attend after death. Director:	<u>₩</u>	Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home	form etre			28f. Location	(Street and Number of	or Rural Route Number, City
Division of Vital Rec pinal or Attending Physician: The ours after death. filted in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined (Specify)	, 101111, 5016	set, factory, emoci	Juliania, oto	or Town,		
y file		29a. Certifier A Contificing Dhysicians To the best of my knowledge	death occu	urred at the time, d	ate and place, an	d due to the ca	use(s) and manner as	s stated.
To the Hos within 24 h To the Fun	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.	or investiga	ation, in my opinior	n, death occurred	at the time, dat	e and place, and due	to the cause(s)
F 3 F 8	Ψ	29b. Signature and title of certifier		29c. Licens			29d. Date signed September 1	(Month, Day, Year) 2 2008
		mes C	<del></del>	O.C.	IVI.⊏.		September	
		Name and address of person who completed cause of death (Item 23     Ana Rubio MD. Assistant Medical Examiner 11	a) 1 Penn	Street, Baltime	ore, MD 2120	01		
Sta	ite	31. Date filed (Month Day Year). 32. Registrar's Signature		-		<del></del>		
Registr		SEP 1 8 2008		Sparth				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Gary Lee Brittingham 2008 entembers /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dorchester prchester General ambridge Hospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 218-34-2912 12/21/1937 Maryland Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Glenburn Avenue Funeral 21613 **USA** 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? ☐ Yes 2 ☐ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No þ If Yes, Give Year or Dates: White 3 Widowed 4 Divorced Specify Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Mail Supervisor Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Edward Brittingham, Sr. 2 Alice Griffith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Linthicum / Niece PO Box 78, Cordova, MD 21625 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 9/11/2008 Hurlock, MD re of Funeral e 22. Name and Address of Facility Mucle Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 Part1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Immediate Cause (Final Onset and Death Advance Chronic Obstructure disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 □ Yes 2 | Jy 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manuar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Division of Vital Records, P.O. Box 68760, attending physician the signed by t d be detach has certificate this after death Director:

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Eversiting must be notified at

filed within 72 hours after

ould be filed withir I Mental Hygiene.

permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked ot any injury or other traumatic even

**Physician** 

Examiner

/Medical

Baltimore, Maryland 21215-0036

n 24 hours aft e Funeral Di eletely filled ir

State

Mary 503 31. Date filed (Month, Day, Year)

Registrar

Medical

29a. Certifier (Check only

29b. Signature and title of certifier

NOMAN

1.4

MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Your BOVE **Physician** HAPLES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mandrin Hospice Home Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oct. 21, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 86 219-16-0023 1921 New Jersey Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at Summerfield Florida Marion 1 ☐ Yes XXNo Director filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 34491 U.S.A. 12327 Southeast 177th Loop Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces? 1943–45
1 XYes 2 No 1943–45
If Yes, Give
Year or Dates: 1951–54 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ other than Elementary/Secondary (0-12) Self-employed Dentist the 7 Is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If item 27 is marked oth any Injury or other traumatic even Be Mary Carmen Scannelli Charles Bove 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Summerfield, FL Barbara A. Bove.wife 12327 Southeast 177th Loop 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery Pages 1 a 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/10/2008 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Michel 4 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 34 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the ! attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🜠 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 201 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Doner Specify Hospic House examiner? 1 ☐ Yes 2 No ပ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

itlu

Registrar

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

SEP 0 8 2008

and address if erson who completed

Ben & fresh

DEFENSE ALGHWAY

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		-	For State Registrar				rtificate					eg. No	100	201.52			
Ph	ysicia	an	1. Decedent's Name (First, Middle								2. Date of Dear Month	th 2 (	Year	3-Time of Death			
X /I	Medic	al	James William F  4a. Facility Name (If not institution,		number)		4b, City.	Fown. or	Location	of Death	9		ty of Death	3:00 aM			
Ex	camin	er	513 Maple Ridge	-	namoer)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	lento		0001			e Arur				
Fun	neral		5. Social Security Number 432-10-2502	6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 5/16/I	Year)	9. Birthp Coun	lace (State or Foreign try) AR			
Dire	ector	-	Usual Residence of Decedent	112x W 201	89	Yrs.					3/10/1919 AK						
yland <b>how</b>	te		10a. State 10b. County		10c, C	ity, Town or Lo	cation						1	0d. Inside City Limits			
ne Mar 8a-fsl	tifled	MD Anne Arundel Odenton  10e. Street and Number  10f. Zip Code  10g. C											1 Yes 2XXNo				
with the	pe no	Dire	10e. Street and Number 513 Maple Ridge	I.ane			10f. Zip		21113	1		_	. Citizen of What Country?  USA				
death ms 23	event, the Medical Examiner must be notifled at	Funeral	11. Marital Status	12. Was D	ecedent Ever in U	J.S. 13.	Was Deced				ecity Yes or No- Rican, etc.)	14. R	ace - Americ lack, White,				
after or ite	mine	y Fu	1 ☐ Never Married 2 ☐ Marri	ed 1 ☐ Yes.	es 2∐No WW Give 7.1	TT	1 ⊟ Yes 2		Specify:		riidan, etc.,	Spec	T.Th. 4				
hours tural",	al Exa	ed by	3 XWidowed 4 ☐ Divorced  15. Decedent	Teal o	r Dates: 41-	I 16a. Dece	dent's Usua	d Occupa	ation		16b. Kind of	Business/Inc	dustry				
nin 72 In "na	Medic	plete	(Specify only highes	t grade complete	e (1-4or 5+)	(Give	kind of wor DO NOT us	rk done d e retired,	luring mos )				·				
ed with	t, the	Completed	Elementary/Secondary (0-12)			Auto	Servi				- /P' 142-H-		motive	2			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.	even	Be	17. Father's Name (First, Middle, James Calvin Bo								e (First, Middle, ohnnie		•				
should mark	ımatlı	₽ .	19a. Informant's Name/Relationsh	nip (Type. Print)	<del></del> .	19b. Maili	ng Address	(Street a	and Numb	er or Rur	al Route Numbe	r, City or Tov	vn, State, Zip	Code)			
and 2 ealth a	er tra	1	Richard Kevin E	Boyd S	on		Maple				Odento:						
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it. Par irtmen	njury	-	4 □ Donation 5 □ Other (S <sub>i</sub> 21. Signature of Funeral Service	pecify)	Ro	selawn	Cemet 2. Name an		s of Facil		/2008  : ardesty	Fort S					
permit. Departr	any ir		13: 2.0	alochise o			2 Ridg			, 11	napolis			ile, I.A.			
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e be exe	ourial-1	cal Ex	resulting in death) Last	Due	to (or as a conse	equence of);											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  On the Funeral Director: After this certificate has been stinned by the attending physician and	s the t			d		_											
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deatle deatle	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pi	regnant at time of nknown		Other (sp						Month	Day Year			
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ician:	ector,	Be	25. Was case referred to medical examiner?	Hospital				Othe	OF:	_	th (Check only o						
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nding th.	e fune	ation	1	9 1 '	Month, Day Year)	Injury	М		k? Yes 2.[	]No							
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To the	comp	Me	29b. Signature and title of certifie	r	1		29	c. Licens	e number			29d. Date sig	ned (Month	, Day, Year)			
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aa			For State Registrar	1,00	State of Ma	aryiand /	Cert	rtment of t fificate of	neaith and Death	ı Mentai F	Reg. N		8 30453
	Physici	an	1. Decedent's Name (							2. Date of Month	Death Da	ay Year	3. Time of Death
1	/Medic	al	JOSEPH -			iner		4b. City, Town, o	or Location of De			200 8	,
10	Examin	er	University			ical Cer	nter		imore				
	Funeral Director		5. Social Security Num 411-52-997	nber 6.		e (In yrs. last t		If Under 1 Year Months Days	If Under 24 H Hours M		Birth Day Year 7193	9. Birt Co	hplace (State or Foreign untry) TN
	and		Usual Residence of Do	ecedent 0b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
	Maryla -f sho fied at	tor	MD	Anne A	rundel		Arno						1 ∐ Yes 2 <b>x∑x</b> No
	th the or 28a e noti	Director	10e. Street and Numb	er				10f. Zip Code			10g. C	itizen of What Co	untry?
	ath wil		624 Andre	w Hill	T				21012		<u> </u>	USA	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show ural Examiner must be notified at	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>3 ☐ Widowed 4 [</li></ul>		12. Was Decedent Armed Forces?  Yes 2000 If Yes, Give Year or Dates:		4	as Decedent of I Yes, specify Cub □Yes 2 <mark>∑</mark> No		(Specify Yes or erto Rican, etc.)	No-	14. Race · Ame Black, White Specify: W	
Baltimore, Maryland 21215-0036		Completed	15	5. Decedent's E only highest gr	ducation		(Give k	ent's Usual Occu ind of work done O NOT use retire	during most of v	vorking	16b. I	Kind of Business/	Industry
121	filed wit Hygien other tha	Con	17. Father's Name (Fig.		5+			Engineer		lame (First, Mide		estingho	ouse <del>UNK</del>
land	2 should be filed withir is and Mental Hygiene. is marked other than aumatic event, It and a	To Be	Joseph C.		,				1	Petit	no, marao	, Carriario,	02120
, Mar)	and 2 should saith and Mer of 27 is marke er traumatic		19a. Informant's Nam Maria Apa:				-			Rural Route Nui Arnold,		or Town, State, 2	Zip Code)
ore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.	10	20a. Method of Dispos		Removal from State	20b. Place ceme	of Dispos etery, crem	tion (Name of atory or other pla	ce)	Date	20c. l	ocation - City or	Town, State
Itim	artmer artmer ortant: injury	-	4 ☐ Donation 5 21. Signature of Fune		•	Atlar		Cremator		6/2008		n Burnie	
Ba	Depa Impo any is	ļ	73	2.0	11500			Ridgely		ardesty Annapol:		ral Home D 21401	e, P.A.
9	Physician /Medical Examiner		23a. Part1. Enter the shock, or heart i Immediate Cause (Fi disease or condition resulting in death)	failure. List only	nplications that caused one cause on each li a	ne.	id h	the mode of dy				1 Concer	Approximate Interval Between Onset and Death
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	aw requires that the das been signed by the 2 should be detached	by	Part II. Other significa	ant conditions	contributing to death b	ut not resulting	g in the und	derlying cause gi	ven in Part I.		d tobacco		the cause of death?  robably 4 ₩Unknown
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/ita	cian: ertifica ector, p	BeC	25. Was case referred examiner?	d to medical						Death (Check on			
of \	ding Physician: The intermonant of the intermonant		1 Yes 2 No.	0	Hospital: 1 Inpatie	ent 2 ER/0	Outpatient	3 ☐ DOA Ott		g Home 5 ☐ R		6 Other (Spe	cify)
Division of Vital Records,	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	Certification: To	1 X Natural 2 ☐ Accident	5 Pending investigation 6 Could not to determine or the could not the co	(Month, Da	y, Year)	Injury	M 1 I	rk? ]Yes 2 □ No	28f. Location	·	and Number or R	ural Route Number,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical Co			hysician: To the best miner: On the basis of and manner st	of examination							
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			Bir	nards	N.D.			PS	211411			9/4/2	800
(1,4	+4-1		30. Name and address	s of person who	completed cause of c	77 5	GER	rint)	, ,	Balti	mor	e Mi	21201
	Sta Registr	te ar	31. Date filed (Month,	SEP 0 8	2008 32. Halistr	ar's Signature	X A	more					

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ORIGINAL

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State of Maryam of Departmens Median And Median Hygiene

		•	For State Registrar	otato of Maryland	Certificate of Dea	th Reg.	No. 0000 001 51
	Di		1. Decedent's Name (First, Middle, La	st)	<u> </u>	2. Date of Death Month	Day Year 3. Tirhe of Death
	Physici /Medio		Cho	on H. C	hoi		5-2008 10:05 AM
	Examin	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Locat		4c. County of Death
		щ	17060 KinG 5. Social Security Number 13 6. S	James Way		nder 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		472-02-0504 Usual Residence of Decedent	□M 200F 80	Yrs. Months Days Hou		ear) Country)
	yland yow		10a. State 10b. County		, Town or Location	_	10d. Inside City Limits
	a-fsh	ctor	MD Mont	gomery C	raithersbur	9	1 Somes 2 □ No
	or 28	Dire	10e. Street and Number	4	10f. Zip Code		. Citizen of What Country?
	ath w	Funeral Director		James Way #	710 2087	<u> </u>	14. Race - American Indian,
	item:	-une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No	S. 13. Was Decedent of Hispanio If Yes, specify Cuban, Mex	xican, Puerto Rican, etc.)	Black, White, etc.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanting rough be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2111 No Spe	ocify:	Specify: Asian
2-0	72 ho 'natur dical	Completed	15. Decedent's Ed (Specify only highest gra	Jucation ade completed)	16a. Decedent's Usual Occupation (Give kind of work done during	most of working	b. Kind of Business/Industry
121	e filed within al Hygiene. I other than " vent, he Me	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		Prut
d 2	filed v Hygie other i	သိ	17. Father's Name (First, Middle, Last,	)		Mother's Name (First, Middle, Mai	iden Surname)
lan	d be ental	To Be	Yong	Gim		150° Ha	<b>N</b>
ary	2 should and Mer Is marke aumatic	۲	19a. Informant's Name/Relationship (		19b. Mailing Address (Street and No	umber or Rural Route Number, C	city or Town, State, Zip Code)
	and 2 salth a		Chris Choi	(son)	17060 King 3	James Way	the Gaithersburg 208 c. Location - City or Town, State
ore	es 1 a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		emetery, crematory or other place)	· ·	,
altimore,			4 Donation 5 Dother (Specif	y) No-	rbeck memorial	19-8-08 6	dessisons mortuary
Bal	permit. Pa Departmer Important: any Injury		21. Signature of Funeral Service Licer	ma1358			
			23a. Part 1. Enter the disease, or com	plications that caused the death	n. Do not enter the mode of dying, sud		AP roximate Interval Between
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	pa iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):	Pan to	1 0
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687	rtificate be executed ng physician and as the burial-transit	Medical		. d			
Box	Se di		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal			23d. Date of delivery
O. B	law requires that the death as been signed by the atter 2 should be detached for	Physician/	in the past 12 months?	4 ☐ Pregnant at time of d			Month Day Year
P.(	ires that the de signed by the a I be detached for	Phy	9 ☐ Unknowh  Part II. Other significant conditions of	contributing to death but not resu	ulting in the underlying cause given in F	Part I 23e Did tobac	cco use contribute to the cause of death?
ds,	signe d be c	d by	10 CarA	2	and in the distance of the second sec	1 □ Yes	2 No 3 Probably 4 Unknown
200	w requir	Completed				24a. Was an	24b. Were autopsy findings available
Re	The lav ate has bage 2 s	dmc		,		autopsy performe	prior to completion of cause of d? death?
ta	an: T	മ	25. Was case referred to medical		26. F	1 ☐ Yes 2 Place of Death (Check only one)	No 1 □Yes 2 □No
<b>\S</b>	nysicl nis cer direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	Other:	☐ Nursing Home 5 Residence	ce 6 Other (Specify)
0	Attending Physician: The I or death. ector: After this certificate ha by the funeral director, page	on:	27. Manner of Math Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of lnjury at Work?	28d. Describe how	injury occurred
sio	tendi leath. tor: / the fu	cati	2 Accident investigation 3 Suicide 6 Could not b	0	M 1 □Yes		
Division of Vital Records,	i di ti	Certification:	4 ☐ Homicide determined		me, farm, street, factory, office	City or Town, S	et and Number or Rural Route Number, State)
_	spita nours neral / filled				wledge, death occurred at the time, da		
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical	(Check only 2 Medical Examone)	miner: On the basis of examina and manner stated.	tion and/or investigation, in my opinion	n, death occurred at the time, date	e and place, and due to the cause(s)
	Vith To th	Ž	29b. Signature and title of certifier	A	enching 29c. License num	ber 29d	Date signed (Month, Day, Year)
	3		wavel fr	muno. Al	y signan D	400 H	1-4-81
			30 Name and address of person who	completed cause of death (Item	1 25a) (Type, Print)	1 /2 #3	IA Rockyde ME
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture ture	sel The 12	200
	Registr		SEP 0 9 201		Societies		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amended#7perfam9/10/08pgcBCJ Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09-05-2008 **Physician** 8:40 P M WILLIAM HENRY COREY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Indian Head 10850 Indian Head Highway Unit 106 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 10-03-1913 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** North Carolina 14€ M 2 □ F 05 94 246-09-3056 Director Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modeal Expressor in set be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 1 EHYes 2 □ No Directo Maryland | Prince George's Indian Head 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 10850 Indian Head Highway Unit 106 20640 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ **Black** 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lettice House Alonzo Corey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 River Forest Ln. Ft. Wash., MD 20744 J.Deanna Easley/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 9/10/08 |Riverdale, Maryland Riverdale Pk.Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee -Moi246 Tack A. Cedar Hill FH 4111 PA Ave. Suitland,MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and physician a s the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5₺ Residence 6 ☐ Other (Specify) 1 Yes 2 ♠ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death,

Director: #
d in by the fu death, 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Lovingih Rond Pt wasping known

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State Registrar

sin war ly 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 11:30 A September 7, 2008 Κ. Campbell Mildred 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Rockville Casey House 8. Date of Birth (Month, Day, ) August 16, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours Min. Days 87 1 □ M 2 1 F 579-18-7488 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2KKNo Montgomery **Rockville** Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20850 1235 Potomac Valley Road 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes X氏 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No White Specify Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Curtin Elmer Richard Padgett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14010 London Lane Rockville, Maryland 20853 Michael Auth / Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 09/10/2008 Forestville, Maryland Epiphany Episcopal Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Moe George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Pat Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CEREBRAL VASCULAR ACCIDENT Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Fctopic pregnancy Year Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

10a. State

Director

Funeral

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Completed

Be

**Examiner** 

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

alth and Mental Hygiene.

27 is marked other than "r r traumatic event, the Med

permit. Pages 1 and 2:
Department of Health as Important: if item 27 is any injury or other traus

Pe

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner burial-tran physician the burial Physician/Medical ding p nse atter for cate has been signed by the page 2 should be detached \$ Completed Be Certification: To this spital or Attending P nours after death. neral Director: After t y filled in by the funera After

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗓 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Septicemia 24a. Was an 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient 28b. Time of

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown

performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

Hospice

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No

2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier J. iauatchou, ms

determined

4 Homicide

(Check only

29a. Certifier

Medical

29c. License number 200 63748 29d. Date signed (Month, Day, Year) September 7, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouathchou MD 6001 Muncaster Mill Road Rockville, Maryland 20855

State Registrar 2008

Hospital 24 hours a Funeral C

To the Hosp within 24 ho To the Fune completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06923 State of Maryland / Department of Health and Mental Hygiene Robert Wayne Davis 1- For State
Registrar

1. Decedent's Name (First, Middle,Last) Certificate of Death Reg. No.

edical Exami		Robert Wayne Davis	Month Septembe	Day Year r 10, 2008	1237 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Decade Sanctuary Lane  4c. City, Town, or Location of Decade Sanctuary Lane  4c. City, Town, or Location of Decade Sanctuary Lane	ath -	4c. County of Dea Frederick	h
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24t	Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. B	rthplace (State or
Director			Dec 25	5.1963 Fore	outing Outing
		Usual Residence of Decedent	1000.23	,,,,,,,,	
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits  1 Yes 2 No
Maryland 28a-f show	to	Maryland Frederick Frederick  10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	
ne Mary or 28a- fied at	Director				
ith th		3031 Sanctuary Lane 21701  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	Specify Yes or No	- 14. Race - Ame	rican Indian, Black,
death with the Maryland or items 23a or 28a-f sh must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? 1 X Yes 2 No		White, etc.	
after al", c	by F	3 Wildowed 4 Divorced If Yes, Give Year 1982—1988 1 Yes 2 X No specify:			hite
hours natur Exami	edk	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business	/Industry
215-0036 be filed within 72 hours ntal Hygiene. rked other than "natur ent, the Medical Exam	Completed	Elementary/Secondary (0-12)		Gove	rnment
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	E O		ame (First, Middle, I		i imeri
21215-( uld be filed Mental Hyg marked oth	Be (	Ronald Lee Davis	Isabel	Stewart	
Z 5 6 2	မ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number		-	
ore, MD 2 ss 1 and 2 shou of Health and N If item 27 is n her traumatic	***	Jean I. Davis - Mother 351 Winding Oak Driv  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	ve Hager Date	stown, Mar 20c. Location - City	y I and 21/40 or Town, State
Ore, gesla of He If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)			·
Baltimore, pernit. Pages 1 an Department of Her Important: If ite		4 Denayor 5 Other Specify Smithsburg Crematory Sc 21. Snatur of Fune Heavy Licit See			, Maryland
Baltimore, MI permit. Pages 1 and 2 s Department of Heafth a Important: If item 27 injury or other traum		papor ne i unei ai i n			м <sub>D</sub> 21795
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Cardiac tamponade			Death
Kallillei		or condition resulting in death)  Due to (or as a consequence of):			
	ř	Sequentially list conditions, if any, leading to immediate be believed. Because by Buptured myocardial infarction  Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated) c. Coronary artery thrombosis			
cuted und transit	Exa	events resulting in death) Last  Due to (or as a consequence of):			
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68760, certificate be ex nding physician se as the burial	sician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ery
ox 687 sath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pre	egnancy	Month	Day Year
Box e death of the atter	ysic	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify) 9 Unknown			
F.O. Bc ires that the des signed by the a signed by the a	, Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute	
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rds v requi	lete	p	24a. Was autor	psy prior to	autopsy findings available ocompletion of cause of
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of Vital Records, ng Physician: The law requir offer this certificate has been so meral director, page 2 should	ToE	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA	ursing Home 5	Residence 6 V Oth	ner: Scene
_ = - ~ 2	on:	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No		now injury occurred	
Division tal or Attendi rs after death. al Director: //	cati	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or	Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town,		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	al C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cau	se(s) and manner as si	ated.
To the within To the comple	ledical	one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date		
	Ž	29b. Signature and title of certifier  29c. License number		29d. Date signed (A	
		Calumy O.C.M.E.		September 11,	2006
119.1		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
H8+1	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature			
Regis		SEP 1 2 2008 Bean & Mark			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 8:41A M **Physician** September 4 Laura Catherine Davis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington County Hagerstown 1113 West Church St. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day), Year Oct. | 14, 1947 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** West Virginia 1 □ M 2 🛣 F 579-62-4587 61 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2001. Other traumatic event. The Market and plucy or other traumatic event. The Market and plucy or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a, State 1 ☐ Yes 2 ☐ No Completed by Funeral Director Washington County Hagerstown Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 1113 West Church St. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Married Specify: White 1 □Yes 2 X No Specify: 3 ☐ Widowed 4 🗓 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Company Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Unkown ၉ Paul Lauder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1113 West Church St. Hagerstown, MD 21740 Jim Baker- Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Smithsburg Crematory 9-6-2008 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** DIONUIU disease or condition resulting in death) /Medical Due to (or as a consegue ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 1 ☐ Yes this certificate Was case examiner? 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No death. illed in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

DH-1

State Registrar

Year) 31. Date filed (Month, Day, 2008

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Anthetam St. Hagerston

29d. Date signed (Month, Day, Year)

29c. License number

MD HOO62598

Registrar

State

Date filed (Month, Day, Year)

SEP 0 9

2008

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

32. Egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 4, 2008 **Physician** 7:00 Ам Mary Clark Devereux /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Somerford Place Columbia Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/14/1915 **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🛛 F Months Days Hours Min. 93 **Director** 186-09-2459 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits s 23a or 28a-f short Columbia Maryland Howard Directo 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 United States 8220 Snowden River Parkway #48 Funeral 12. Was Decedent Ever in U.S. Armed Forces? or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner 1x Yes 2 No World 1 Never Married 2 ☐ Married If Yes, Give Year or Dates War II þ 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Naval Communications US Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 27 Is marked ot any Injury or other traumatic ever Pages 1 and 2 should be 'nent of Health and Mental Elisabeth Clarke James Ashton Devereux 19a. Informant's Name/Relationship (Type. Print) Executor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen B. Elkins / Nephew and Seclusion Ct. #C Raleigh, NC 27612 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Silver Spring, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Heaven Cemet</u> 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the dise, se, or complications that shock, or heart failure. List only one cause on ulled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Berosciero disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical the attending phone IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ icate has been si ; page 2 should t 2 No 3 Probably 4 W Unknown Completed 24a. Was an 24b. Were autopsy findings available Be Certification: To

P.O. Box 68760 Division of Vital Records,

filed within 72 hours after death

3altimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
24 hours after death.
25 hours after this certificate has been signed by the attending physician and selve filled in by the funeral director, page 2 should be detached for use as the burnar-transit n 24 hours af le Funeral Di letely filled in

To the l within 2.

					performed?	death? 1 □Yes 2√2 No		
25. Was case referred examiner?	d to medical			26. Place of De	eath (Check only one)			
1 Yes 2 M	o	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3 □	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	Other (Specify)		
2 Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factorify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1[ (Check only 2]	Certifying Ph	ysician: To the best of my knoniner: On the basis of examination	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)		

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ur. Obborch PIERCE

Smith 2835

State Registrar

Medical

31. Date filed (Month, Day, Year)

SEP 0 9

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 30461

Stefanie Nicole E		ards I- For State Registrar	State of Maryla	and / Departm <i>Certific</i>			Mental H		. No.	00 3040			
Physicia Medical Exami	ın/	1. Decedent's Name (First, STEFANIE	Middle,Last) NICOLE	EDWARDS			TO 1 4 15	2. Date of Death Month September	Day Year 17, 2008	3. Time of Death 0116 hrs			
· Par		4a. Facility Name (if not inst Upper Chesapeak		umber)	4	b. City, Town, or L Bel Air	ocation of Death		4c. County of Dea Harford	th			
Funeral Director		5. Social Security Number 219-17-05	6. Sex	7. Age (In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Mir	-	(MM/DD/YYYY) <sup>9. B</sup>	irthplace (State or Foreign ountry) Maryland			
w any		Usual Residence of Deceder 10a. State 10b. Co	ounty	10c. City, Towr		on				10d. Inside City Limits			
ith the Maryland 23a or 28a-f show	Director	10e. Street and Number	arford thridge Di		AII	10f. Zip Code 21015		10	g. Citizen of What Co				
ath w	uneral	11. Marital Status  1 X Never Married 2	12. Was De	cedent Ever in U.S.		S Decedent of Hisp es, specify Cuban,			White, etc.	erican Indian, Black,			
hours after de natural", or Examiner m	ed by F	Widowed 4  15. Decedent's Education	Divorced If Yes, Give Ye or Dates:  (Specify only highest gra	ar ade completed) 16a.	Deceden	Yes 2 X No t's Usual Occupationst of working life.	on (Give kind of		Specify: V	Thite Hindustry			
5-0036 fled within 72 Hygiene. d other than " the Medical!	ompleted	Elementary/Secondary (0 1 1 1 17. Father's Name (First, M		1-4 or 5+)	Reta:	il Sale		k e (First, Middle, M	Retail	Sales			
21215 ould be filed Mental Hy marked of	o Be C		ld Edward		9b. Mailing		Lynda	Dowlin		ite, Zip Code)			
MD nd 2 sho alth and m 27 is		Lynda Edw 20a. Method of Disposition		other) 2	2117 of Dispos	Northr	idge D		Air, MD.	21015			
_ <b>.=</b> 6 8 8 6		1 X Burial 2 Cren 4 Denation 5 Oth 21 Signature/of Fun 1 Se	ner Specify	st.	22 N	l's Cem	of Eacility	22/08		town, MD.			
Balt Permit. Depart Import injury		23a Part I. Enter the diseas	se, or complications that	M00510	not enter th	alena F 18 West ne mode of dying, s	uneral Cross such as cardiac	Home C St. Ga or respiratory arre	I Stephe Iena, MI st, shock, or heart	21 Schaeo 21635  Approximate Interval Between Onset and			
/Medical xaminer		Immediate Cause (Final dis or condition resulting in dea	sease a Compli	ications of a consequence of):	Met	hadone a	nd Alco	hol Into	xication_	Death			
<b>N</b> - =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.											
50, Ke be executed to be executed sysician and transit	edical E	X UNPENDED	d AMENDED	23a,27,28	a-f 1	per me g8	885 11-1	9-08 vt					
Sion of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate to death ector: After this certificate has been signed by the attending physi by the funeral director, page 2 should be detached for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnar past 12 months?  1  Yes 2  No 9 ✓	decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)										
P.O. E es that the digned by the	ò	Part II. Other significant c			ng in the ι	underlying cause g	ven in Part I.			to the cause of death?			
of Vital Records, ng Physician: The law requin After this certificate has been s meral director, page 2 should	Completed							24a. Was a autop: perfor	sy prior t med? death				
Vital F ysician: his certifi director,	o Be C	25. Was case referred to mexaminer?  1 ✓ Yes 2 No.	Hospital:	Inpatient 2 ER/G	Outpatient		of Death (Chec Other: Nurs		Residence 6 Ot	ner:			
on of cending Pheath	ıtion: T	27. Manner of Death 1 Natural 5	28a. Date (Monited Pending Q-1	th, Day,Year)	. Time of I	1 1	y at Work? es 2 🗶 No	28d. Describe h	ow injury occurred	,			
∑ કહે ≒ાં ∐	Certification	3 Suicide 6 X	determined (Specify	TOURG IN	hote	el room		or Town, S Edgewood	ate) 2700 Pu	Rural Route Number, City  1aski Hewy  #221			
Di To the Hospital within 24 hours a To the Funeral	Medical	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the be al Examiner: On the basis and manner	of examination and/or	eath occur rinvestiga	rred at the time, da tion, in my opinion,	te and place, ar death occurred	at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)			
	Me	29b. Signature and title of o		> M	5	29c. License O.C.N			29d. Date signed (I September 17				
		30. Name and address of p Russell Alexande	r MD. Assistant	Medical Examine		Penn Street,	Baltimore, N	MD 21201					
St Regis	late trar	a	Year) 32. F	Registrar's Signature	Sound !				OCME				
DHMH 17 Rev 1/2	001	4000	4	0	RIGINA	L							

08-06773 Stephen Allen Fowler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 30462

ICIT / MOTITO	1	- For State	•	Certific	ate of L	Death				. No		3. Time of Death
Dhysisia		tegistrar 1. Decedent's Name (First, Middle,La	st)					2.	Date of Death Month September	Day Yea		1201 hrs
Physicia ⊓ ≺l Examin		STEPHEN		OWLER					September	4, 2008	-f Dooth	12011110
LAUIT		4a. Facility Name (if not institution, gi			4b	. City, Town, or I	ocation of	Death		4c. County Calvert	or Death	
	П	719 Lazy River Road	,			Lusby		-42			ol o Biet	hplace (State or Foreign
_	-	Social Security Number 6. 5	Sex 7. Age (	In yrs. last bir	thday)	If Under 1 Year			8. Date of Birth	RY 06	LO	untry), DG
Funeral Director		01E 00 6112	XM 2 F	42	Yrs.	Months Days	Hours	Min.	07111011	1966	'Was	shington,
Director	-		ZJW 21			l	1					10d. Inside City Limits
	-	Usual Residence of Decedent  10a. State 10b. County	10	0c. City, Towr	or Locatio							1 Yes 2XXNo
w any	- 1	MD CALV	ERT			LUS	BY					
land f she	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of W	hat Cour	ntry?
Mary 28a	ည	719 LAZY RIVE	CANA G		-	20	657		ļ.	UNITE	D ST	TATES
death with the Maryland or items 23a or 28a-f show must be notified at once.			12. Was Decedent E	ver in ILS	13. Was	Decedent of His	nanic Orig	in? (Spe	cify Yes or No-			ican Indian, Black,
h with	era	11. Marital Status  1 Never Married 2 X Marrie	Armed Forces?	_	If Ye	es, specify Cubar	, Mexican,	Puerto R	(ican, etc.)	VVIII	te, etc.	
deat or ite	Funeral		1 Yes 2X	ΧNο	1	Yes 2XXNo	specify:			Specify	:	WHITE
after	by	3 Widowed 4 Divorce 15. Decedent's Education (Specify		pleted) 16a	Decedori	le Heual Occupa	tion (Give I	kind of wo	ork done	16b. Kind of E	Business/	/Industry
hours		15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5-		during mo	ost of working life	, DO NOT	use retire	ea)			
n 72 n 72 ical	plet	12TH	00030 (	ĺ	U	NEMPLO						
withi jene.	Completed	17. Father's Name (First, Middle, La	ast)							Maiden Surnan		
filed Hyg			NNIS FOWI	ER			GLO	RIA	ANN I	YON S	AND!	BERG
21215-0036 mild be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stre	et and Nur	nber or R	ural Route Nu	mber, City or To	own, Stat	20657
D 2 shoul and N 7 is n	Ĕ	CHERYL L. FOW	LER / WIFE			LAZY RI		ROA		SBI, M	_	or Town, State
, MD 21215-0036 and 2 should be filed within 72 hours after ten 21 and Mental Hygene. ten 27 is marked other than "natural", tranganic event, the Medical Examiner.				20b, Plac	e of Dispos	ition (Name of co	emetery,	SEP'	T 07			
imore Pages 1 a ment of H tant: If it		1 Burial 2 XXCremation	3 Removal from Sta	te METT	(OPOI	CTTTAN	ਸ	2	800			xandria,VA
Pag ment tant:		4 Donation 5 Other Spe 21. Signature of Funeral Service Li	cify:	1	RAL 22.1	SERVIC	ss of Facilit	ty TOII	NICON	FINERA	T. S	ERVICE, PA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		atenence	-	Kusir	~ h4	ERRENC!	e Pi	JOH Lain	inson Is Ln.	, White	PI	ERVICE, PA
and Completely		TERRENCE L 23a. Part I. Enter the disease, or co	JOHNSON omplications that caused	the death. Do	not enter	he mode of dyin	g, such as	cardiac o	r respiratory ar	rest, shock, or	heart	Approximate Interval Between Onset and
Physician Medical		failure. List only one cause o	n each line. a. Intraoral Shotgu									Death
∡aminei		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	equence of):								
			b.									
	ā	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):								
	۽	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a cons	earronce of/:								
b is	Evamine	events resulting in death) Last	·									
760, icate be executed physician and the burial - transit	1 4		d. X AMENDED 28	f, per	ME,	g883 9/2	23/08	TT				
), be ex sician	Modical	UNPENDED	23c. If yes, outco							23d. Dat	e of deliv	
760, icate b			e 1 Live birth	ine or pregna	2 F	etal death	3 Ecto	pic pregn	ancy	Mont	th	Day Year
Box 687: death certific		past 12 months?	4 Pregnant a	t time of deat		Other (Specify)						
SOX Jeath Jeath		1 Yes 2 No 9 Unk						D. d.I.	23a Dic	tobacco use o	ontribute	e to the cause of death?
D. B. trhe de by the	3   C		ons contributing to dea	th but not res	ulting in the	e underlying caus	se given in	Part I.				Probably 4 Unknown
, P.O	an a	<u> </u>							24a. W			e autopsy findings available
rds, requir	pino	91							au	topsy	prior deat	to completion of cause of
law r	US 7	ouppieted								rformed?		Yes 2 No
Records, The law requir	bag c					26.P	lace of Dea	th (Chec	k only one)			
tal Recor	rector, page	25. Was case referred to medica examiner?		tient 2 1	ER/Outpatie	ent 3 DOA	Other:	Nurs	sing Home 5	Residence	6 🗸 C	Other: Scene
r this	ē∖	O 1 Yes 2 No			28b. Time		Injury at W	ork?	28d. Descri Subject S	be how injury o	ccurred	
ing Pl	tunera	27. Manner of Death  Natural 5 Pend	28a. Date of In (Month, Day FOUND:	/,Yeer)	FOUND:	1[	Yes 2	<b>✓</b> No				
ivisior or Attend after death Director:	y the	2 Accident Inve		Injury - At ho	1201 hrs me, farm, s	treet, factory, off	ce building	, etc.	28f. Locatio	on (Street and	lumber c	or Rural Route Number, City
Division of Vital tal or Attending Physician as after death.	filled in by	3 Suicide 6 Cou	Id not be (Specify) S						919 Lazy F	River Road, L	usby, M	ID
. <b>c.</b> 9 <b>c</b> .	/ fille	4 Homicide					e, date and	l place, a	nd due to the	cause(s) and m	anner as	stated.
n 24 h			aminer: On the basis of e	xamination ar	d/or invest	igation, in my op	inion, death	occurre	d at the time, o			
To the within To the	comp	(Check only one) 2 Medical Example 29b. Signature and title of certification of the control of t	dila mamor otata	ed		29c. Li	cense num	ber		290. Dati	e signed	(Month, Day, roar)
		2 29b. Signature and little of certifi				C	.C.M.E.			Septer	mber 5	, 2008
		augoc		f 1Al- /4	230)							
0 22		30. Name and address of perso	n who completed cause of sistant Medical Exa	or death (Item aminer	Հ∞յ 111 Pen	n Street, Bal	timore, l	MD 212	201			
N L L	- 1	Ana Rubio MD. As		_								
DDD		ate 31. Date filed (Month, Sax Year	0 9 2008 32. Red	trar's Sinnati	re .	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Rea. No Registrar Physician/ 1 Decedent's Name (First, Middle Last) 2 Date of Death 3. Time of Death Month Day Year September 15, 2008 1935 hrs Medical Examine Alberta Fauntlerov 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Min. Months Hours Director Country) Virginia 227 70 2559 M 2 X F 60 Yrs Sept 3. 1948 Usual Residence of Decedent 10d. Inside City Limits ű 10a, State 10h County 10c. City, Town or Location "natural", or items 23a or 28a-f show | Examiner must be notified at once. MD P.G. Yes 2 XX No Upper Marlboro 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country 9813 Woodyard Circle 20772 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married 1 Never Married Yes XX No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of
Department of Health and Mental Hygene.
Department of Health and Mental Hygene.
Injury or other tranmatic event, the Medical Examiner. **Black** 4 X X Divorced If Yes. Give Year Specify Widowed Yes 2XX No specify \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Postal Service U.S. Post Office 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ashford Ellison Reva Vaughan æ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Goff (Sister) 9813 Woodyard Circle, Upper Marlboro MD 207
ce of Disposition (Name of cemetery, I Date | 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation Removal from State Cemetery 9/22/2008 | Clinton, MD Resurrection Donation 5 Other Specify 21. Signature of Funcial/Service 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandira Ferry Road, Clinton, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medica Hypertensive atherosclerotic cardiovascular disase Death Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Physician/Medical 23a,2/,perME,g884 10/7/08 TT X UNPENDED AMENDED ed by the attending physician detached for use as the burial Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Day Year Live birth Fetal death Month past 12 months? Pregnant at time of death Other (Specify) Yes 2 V No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, ficate has been si , page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? certificate Yes 2 1 🗸 Yes 26 Place of Death (Check only one) Division of Vital director. 25. Was case referred to medical Be examiner? Hospital: Other; Innatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this ္ 1 ✓ Yes No funeral After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or 24 hours after death.

Funeral Director: A letely filled in by the fu 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

within 2 To the I

Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year, SEP 23 2008

and address of person who completed cause of death (Item 23a)

ORIGINAL

O.C.M.E

111 Penn Street, Baltimore, MD 21201

State

Registra

September 17, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 7, Gladys F. Golden 2008 1:15A. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5903 Lockwood Road Prince George's Cheverly 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year)
July 17,1915 9. Birthplace (State or Foreign Country)
Virginia 7. Age (In vrs. last birthday) Days 1 M 2 X Hours 93 578-46-2741 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Cheverly Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 20785 10g. Citizen of What Country?
United States 5903 Lockwood Road Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ğ 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Rex Corbin Katie C. Ennis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3312 Richwood Lane Brookeville, Maryland 20833 19a. informant's Name/Relationship (Type. Print) Edward M. Golden -son 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) Fort Lincoln Cemetery 9/10/2008 Brentwood, Maryland Bonard V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licenses 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Lymphoma 6months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Inflammatory Bowel Disease; Peripheral Edema 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perlormed? Yes 2 1 No 2 XNO 1 🗆 Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide

Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, has been certificate death.

physician and s the burial-trans attending p ed by the a detached f signed by to page 2 s this certifical After thi funeral o within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the

**Funeral** 

Director

28a-f show

or than "natural", or Items 23a or 28a-f shov

7 is marked other traumetic event, II

Department of Importent: If eny Injury or once.

**Physician** 

Examiner

/Medical

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the Maryland

filed within 72 hours after death with

3altimore, Maryland 21215-0036

State Registrar

Certification: To

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifie

29a. Certifier

31. Date filed (Month, Day, Year) SEP 0 9 2008

determined



recute o

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D17572

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

September 8, 2008

			Please	Type or Print in State of Maryla				-	-	
			For State Registrar	Glate of Maryla	•	rtificate of		_	Reg. No. 2008	30465
	Dhooist		1. Decedent's Name (First, Middle, Las	t)				2. Date of De	ath Day Year	3. Time of Death
	Physici /Medio		CAROLYN HUCKSTI	·				septe	mbon 3, 2008	2326 M
	Examir Funeral Director		4a. Facility Name (If not institution, give Prince George 5. Social Security Number 6.86 226-70-8342	RI HOSPI,	tal rs. last birthday) Yrs.	4b. City, Town, o	execution of Death  execution  If Under 27 Hrs.  Hours Min.	8. Date of Bir (Month, Date 12-07-	ı <i>y, Year),</i> Co	h Cogs hplace (State or Foreign untry) ginia
	and w	1	Usual Residence of Decedent  10a, State 10b, County	10c. (	City, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	힏	Maryland Prince G			tville				1 ∄Yes 2 ☐ No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	th with	ai D	1732 Tulip Avenu	Э		2074	7		USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machael Experient required at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ♣ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 □Yes 2 No	Hispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No Rican, etc.)		
2-0	72 ho	eted	15. Decedent's Ed	ucation de completed)	16a. Dece	dent's Usual Occu	pation during most of workin	na	16b. Kind of Business/	Industry
121	/ithin han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 04	life. I	DO NOT use retire Secretary	d)	.9	Private In	dustry
	filed withir Hygiene. other than ent, the M		12th 17. Father's Name (First, Middle, Last)	04	"	eci ctar y		(First, Middle	, Maiden Surname)	<u> </u>
lan	should be f and Mental I s marked of umatic eve	To Be	Lawrence Hardin				Bernice	Austin	ı	
Maryland	2 shou and N is mar aumat	-	19a. Informant's Name/Relationship (7	ype. Print)	I .	_			er, City or Town, State, 2	
	1 and 2 Health a sem 27 is		Tara Huckstep/dau						st.Hghts,MD	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1段 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			sition (Name of natory or other pla	ce)   D	-2008	Clinton, Ma	
Salt	permit. Depart Import any inj once.		21. Signature of Fane at Service Licen		22 Co	2. Name and Addr	ess of Facility FH 4111 I	PA Ave.	Suitland,M	D 20746
	<b>T</b> □ = <b>e</b> O		23a. Part1. Enter the disease, or comp	MO1521			-			Approximate
	Physician /Medical Examiner		shock, or heart failure. List only inmediate Cause (Final disease or condition resulting in death)	a. Due to (or as a const	√ € √ equence of):	ic Hyp	est ensin	e He	art D's ca	Interval Between Onset and Death
760,	ificate be executed g physician and is the burlat-transit	cal Examiner	Sequentially list conditions, if arty, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consi						
P.O. Box 687	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of preg 1  ☐ Live birth 2  ☐ Fe 4  ☐ Pregnant at time o 9  ☐ Unknown	etal death 3 [	] Ectopic pregnan ] Other <i>(specify)</i> _	су		23d. Date of del Month	ivery Day Year
rds, F	quires tha n signed I uld be det	ρ	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause gi	ven in Part I.		tobacco use contribute to Yes 2 □ No 3 □ Pi	
al Records,	ian: The law requir rtificate has been s ctor, page 2 should	Completed						24a. Was auto perfo 1 □ Yes	an 24b. Were au prior to ormed? death?	utopsy findings available completion of cause of 2 □ No
Vital	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Oti	26. Place of Death			
	ng Ine	tion: To	1 Yes 2 No  27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Inju	4 □ Nursing Hor		idence 6 ☐ Other (Spe how injury occurred	cify)
Division	al or Attending s after death. Il Director: After ed in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, streetify)			28f. Location ( City or To	(Street and Number or Ruwn, State)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b.	Medical C		ysician: To the best of my k liner: On the basis of exam and manner stated.						
	To the within 2 To the comple	ž	29b. Signature and title of certifier	111 1		29c. Licen	se number		29d. Date signed (Mont	h, Day, Year)
	(3)		Laradu	/fyrater !	20	1/2	5592.	)	September	142008
_	Sic		Splus don S	ombleted cause of death (It	tem 23a) (Type,	Print)	el Driv	90	Every 1	inglad
	Sta Registr		SEP 1 0 2008	32. Registrar's Sig	rature			,	0)	

DHMH 17 Rev 1/2001

Registrar

State

30. Name and addess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Robert Henry Harvey, Sr. 8:12 PM September 5. 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Silver Spring

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Renaissance Gardens at Riderwood Village Prince George's 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F 579-20-7253 May 27, 1924 Louisiana Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 25 TNo Silver Spring | 10f. Zip Code Maryland Prince George's 10e. Street and Number 10g. Citizen of What Country? 3148 Gracefield Road, #203 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1943–46 1 Never Married 2 M Married 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Certified Public Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Harvey Sadie Gibson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3148 Gracefield Road, #203, Silver Spring, MD 20904
of Disposition (Name of Date 20c, Location - City or Town, State Gloria Harvey/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 IC Cremation 3 ☐ Removal from State Metropolitan Crematory September 9 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd, W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Lung Cancer 3 Months disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown

Physician /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

2

Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm M-dical Examination and injury or other traumatic event, I'm M-dical Examination and injury or other traumatic event, I'm M-dical Examination and injury or other traumatic event, I'm M-dical Examination and injury or other traumatic event, I'm M-dical Examination and injury or other traumatic event, I'm M-dical Examination and I in the II in the II in the II in the II in the II in the II in the II in the II in the II in the II in the II in the II in II in the II in

Baltimore, Maryland 21215-0036

burial-tran attending physician for use as the buria ed by the detached f signed I has To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, pa

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical 2 Completed Be Certification: To

Medical

State Registrar 25

27.

29a. Certifier

(Check only

							553-52-53	_	autopsy performed?	prior to completion of cause of death?  1 □ Yes 2 □ No
Was case referre	ed to medical						26. Place of [	Death (	(Check only one)	
1 Yes 2 № N	lo	Hospital	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 1	AOC	Other: 4 🔀 Nursin	g Hom	e 5 ☐ Residence 6	Other (Specify)
Manner of Death 1   Natural 2  Accident	5 ☐ Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28	3d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e.	Place of Injury - At h building, etc. (Speci	ome, farm, stree fy)	t, facto	ory, of	fice	28	Bf. Location (Street and City or Town, State)	Number or Rural Route Number,

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D24093

and manner stated. 29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year) September 8, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Parkhurst, MD 3110 Gracefield Road, Silver Spring, MD 20905

32. Figistrar's Signature

			For State Registrar		State	of Mary	/land / [		artment <i>rtificate</i>			and M	lental Hy	giene Reg. No.		3	30468
	Dhusisi		1. Decedent's Name (First, Ma	iddle, La	st)								2. Date of De Month	ath			3. Time of Death
	Physici /Medi		Margaret S. H	larr	ison								Septemb	Day Der 6			7:38 P <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institu						4b. City, To	own, or	Location of		*		County of D	eath	
west.			4932 Sentine1 5. Social Security Number						Beth	esd	a .	04 1100		Mo	ntgom		
П	Funeral Director		188-07-8371	6. 5	ex □M2[x]F		n yrs. last bir	thday) Yrs.		Days	If Under	Min.	8. Date of Bir (Month, Da			Counti	* /
			Usual Residence of Decedent			91							10/24/	1916	Pe	nns	ylvania
	rylan <b>how</b>	_	10a. State 10b. Cou	,		10	c. City, Towr	or Lo	cation			_				10	d. Inside City Limits
	Ba-f s	Director	MD Mont	gome	ry		Bethe	sda									1 XYes 2 □ No
	ith th	Dire	10e. Street and Number						10f. Zip C	ode				10g. Citiz	zen of What	Countr	y?
	s 23a	<u>ra</u>	4932 Sentinel	L Dr					208	_					ed St	ate	S
	item item	Funeral	11. Marital Status		12. Was Dec	orces?	in U.S.	13. \	Was Deceder f Yes, specify	nt of Hi y Cuba	ispanic Ori n, Mexican	gin? (Spe ı, Puerto I	cify Yes or No Rican, etc.)	-   1	14. Race - A Black, W		
336	Irs aff	by	1 ☐ Never Married 2 ☐ M 3 文 Widowed 4 ☐ Divord		If Yes, G Year or I	2X No ive lates:			l∐Yes 22	No No	Specify:				Specify: W	√hit	e
ŏ	2 hou	ted	15. Dece	dent's Ed	fucation		16a.		dent's Usual (					16b. Kin	nd of Busine	ss/Indu	ıstrv
215	hin 7. e. an "n	ple	(Specify only hig Elementary/Secondary (0-12	nhest gra	de completed) College (		-111	(Give	kind of work OO NOT use	done d retired,	luring most )	of workir	ng				,
2	ed wit	Completed	12		- Conoge (	1 40/ 01/	Ti	cke	t Agen	nt				Air	line I	ndu	stry
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Mcdical Evan, for inter the notified at	Be	17. Father's Name (First, Midd										(First, Middle,	Maiden 5	Surname)		
<u>X</u>	Men Men Marke Marke	은	Charles H.								Blar	nche	Hewitt				
<u>a</u>	es 1 and 2 should bot Health and Ment item 27 is marked other traumatic	1 10	19a. Informant's Name/Relatio										Route Numbi			e, Zip (	lode)
മ്	1 and 2 Health em 27 i		Joan Bejean / 20a. Method of Disposition	<u>Nie</u>	ce	12		-	x 8390 sition (Name		ither		g, MD			or Tow	n State
o D	ages int of t: If it		1 ☐ Burial 2 🛣 Crematic			State	cemeter	y, cren	atory or other	er place		_			eation - City 5 Chur		
baltimore,	permit. Pages 1 Department of I Important: If ite any injury or of once.		4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Servi			T.	- Tation			-	i	-	eph Ga				
g	Depar Depar Impor any ir		14)		111.								NW Was				
			23a. Part 1. Enter the dise e shock, or heart failure.	, or com	olications that	caused the	death. Do r	-								-	Approximate nterval Between
. F	hysician		Immediate Cause (Final	ist only													Onset and Death
	/Medical		disease or condition resulting in death)				's De		tia							3+	Years
E	Examiner			•		(-, 40 4 50		,.									
	o .±	je l	Sequentially list conditions, if any, leading to immediate cause. Each of darying Cause (Disease or injury that initiated events	J	Due to	(or as a cor	nsequence d	of):									
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c												
9/00,	cian (	<u></u>	resulting in death) Last		Due to	(or as a cor	nsequence o	of):									
0	after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	dical			.d				-							+-	
X	attending p	/Me	IF FEMALE:		23c. If yes, ou	tcome of pr	egnancy				lkel.						
YOU !	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?		1 🔲 Live	birth 2   nant at time	Fetal death		Ectopic preg					23	3d. Date of o Month		y Day Year
ָ	by the achec	Jysi	1 □ Yes 2 🔯 No 9 □ Unknown		9 □ Unkr				TOTALOT (OPOC)	,,							
7,	w requires that the or sbeen signed by the should be detached	by P	Part II. Other significant cond	itions co	ontributing to d	eath but no	t resulting in	the un	derlying caus	se give	n in Part I.		23e. Did to	bacco us	e contribute	to the	cause of death?
ords,	quire an sig uld by	pe pe	Coronary Art	ery	Diseas	e, At	rial H	ibr	rillat:	ion	,		1 🗆 Y	es 2K	No 3□	Probal	bly 4 ☐ Unknown
ָ כ	aw reas bear a	Completed	Peripheral V	ascu	ılar Di	sease							24a. Was a	an	24b. Were	autops	sy findings available
ב ב	ate ha	ĕ											autop perfoi 1 □ Yes	med?	death	o comp ? es 2	pletion of cause of
ובים קיי	artific ctor,	Be	25. Was case referred to medie examiner?	cal							26. Place	of Death	(Check only o			65 2	LINO
	this o	2	1 ☐ Yes 2 🙀 No				2 🗆 ER/Out	patient		Othe	4 🗆 (40)	rsing Horr	ne 5 <b>√</b> Resid	lence 6	☐Other (S)	pecify)	
	After	ö	27. Manner of Death 1 □Natural 5 □ Pend	ding	28a. Date (Mon	of Injury th, Day, Yea	28b. T. (ar) In	ime of jury		. Injury Work?	at ?	2	8d. Describe h	ow injury	occurred		
מים ב	the f	cat	2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Coul	stigation ld not be	- Di				М		es 2□N	lo					
2	after Direction by	Certification:	4 ☐ Homicide dete	rmined	buildi	ng, etc. (St	ec <i>ify)</i>	m, stre	et, factory, of	ffice		2	Bf. Location (S City or Tow	treet and n, State)	Number or	Rural F	Route Number,
- letine	ours neral filled		29a. Certifier 1K Certifi	vina Phy	/sician: To the	hest of my	knowledge	death	occurred at	the tim	o dato and	d place a	nd due to the	201125/2			A1
Į.	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	(Check only 2 ☐ Medic one)	al Exam	iner: On the b	asis of examer stated.	mination and	/or inv	estigation, in	my op	inion, deat	h occurre	d at the time,	date and p	place, and d	ue to t	ne cause(s)
4	Mithir Somp	ĕ -	29b. Signature and title of certif	fier	C			^	29c. Li	icense	number			29d. Date	signed (Mo	nth, Da	ay, Year)
			I alan m	. h	)emtr	aul	m	1	MDO	001	1697				8/2008		
,	10	-	30. Name and address of person						rint)						,		
			ALan M. Weint		MD 55	30 Wi	sconsi	n A	ve. Ch	hevy	y Cha	se, l	MD 2081	.5			
	Stat	Ÿ	31. Date filed (Month, Day, Yea			egistrar's S			w =								
	Registra		SEP 0 9	ZUUS	Street	AST A	5 A	2546	U_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 9:44 A<sub>M</sub> Arva Tingle Hall Sept. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1601 Winthrop Place Salisbury Wicomico | If Under 14 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | Aug. 22, 1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F 214-10-6315 94 Yrs Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Itame 23a or 28a-f show r then "naturel", or Iteme 23e or 28e-f sho the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1601 Winthrop Place 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Clothing Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. 10 Presser Manufacturing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 le marked othe eny light you other traumatic event, sons. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lloyd Russell Tingle Jerdie Marie Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty E. May/Daughter 1601 Winthrop Place, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatiop 5 ☐ Other (Specify) Melson Cemetery 9/9/2008 Delmar, Maryland 22 Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Rod. Salisbury, 21. Signature of Funeral Service Licers 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immédiate Cause (Final disease or condition resulting in death) HYPERTENSION Due to (or as a consequence of): Physician UNKNOWN /Medical Examiner NIDDM 2, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit C40 1, Due to (or as a consequence of): OZON CANCER Physician/Medical 1, attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **P**No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has t irector, page 2 s autopsy performed? Yes 22No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 No ŧ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred 1 Matural 5 Pending death. Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral C completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9-8-08 05092 9

DHMH 17 Rev 1/2001

State Registrar

P.O. Box 68760,

Division of Vital Records,

MO

SALISBURY

Joy Madarang-Lewis, M.D.

21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST

32. Paistrar's Signature

DIVISION

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SEP 1 0 2008

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day<sub>5</sub> September 2008 Deborah Lillian Hait 9:21 P M 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 28, 1 Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2√2 F 519-70-9704 Florida 49 1959 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ∏Yes 2 □ No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Gateway Drive 21788 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Lloyd McDaniel Vera Lampert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick A. Hait / Husband 520 Gateway Drive, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 9/7/08 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses ROBERT ded Control & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TOMOROFY Due to (or as a consequence of): Months Met actale Se uentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 2 🔽 1 □Yes 26. Place of Death (Check only one) 1 4mpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

Director

Funeral

3

Completed

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Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Evantice count by Indical Evantice count.

Baltimore, Maryland 21215-0036

the burial-tran attending physician for use as the buria page, certificate director. this funeral After t n 24 hours after death.

e Funeral Director: A letely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Examine Physician/Medical ş Completed Be Certification: To

25. Was case referred to medical 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Aatural 5 | Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)



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29b. Signature and title of certifier

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29c. License number

29d. Date signed (Month, Day, Year)

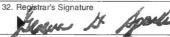
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State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 0 8



Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date 3. Time of Death 2008 O 10:30PM Paul E. Hudson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Salisbur HOSPICE at the aKP WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 1**⊠**M 2□F Months Days Hours Min 65 214-42-8484 1943 Delaware July 3,Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 TNo Mardela Springs Wicomico 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 25005 Ocean Gateway 21837 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Nylon Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin Hudson Alice Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia S. Hudson Mardela Springs, MD (Wife) 25005 Ocean Gateway 21837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mardela Memorial Cem. 09-10-2008 Mardela Springs, MD 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licenses 13 E. Grove Street 19940 Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEURORNDOCRINE PANCREATIC CARCINEMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 **7**No

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or items 23a or 28a-f shoved at examiner must be notified at

the Medical

Director

Funeral

Completed by

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MD

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite

Department of Health mportant: If item 27

injury or other

Maryland 21215-0036

Baltimore,

Paul

Examiner

physician and s the burial-trans signed by t d be detach After this Director:

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a To the Funeral C State

Registrar

Medical

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Completed by 25. Was case referred examiner? Be 1 ☐ Yes 2 🗹 🕅 o P Certification: 27. Manner of Death 1 Natural 2 Accident 6 ☐ Could not be 28e Place of injury . At home farm street factory 3 ☐ Suicide 4 Homicide

(Check only

to medical							26. Place of Death (Check only one)							
	Hospital:	1 Mpatient	2 🗆	ER/Outpatient	3 🗆 [	OOA	Other: 4	☐ Nursing H	ome	5 Residence	6 □Other (Specify)			
☐ Pending investigation		Date of Injury (Month, Day Yo	ear)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 □ No	28d.	Describe how inju	ury occurred			

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determined	building, etc. (Specify)
arminad	20e. r lace of alluly - At home, famil, street, factory, office

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and litle of certifier	29c. License number
18	D00586

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Hayon WAR

PU BOX 1737

31. Date filed (Month, Day, Year) SEP 09 Goade

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Charles Edward Harmon 2008 0903 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death PENINSULA REGIONAL MEDICALCANTE WICOMIC Age (In yrs. last birthday 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) Months Hours 214-32-0569 Feb 23,1936 MO Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 □ No MID Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2000 Whispering Pond Ct. 21804 12. Was Decedent Ever in U.S. Armed Forces? 1 இYes 2 □ No Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1'g]Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify Specify: African-3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self employed 12 Cleaning Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawrence Harmon Marjorie Corbin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Harmon/wife 2000 Whispering Pond Ct., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 9/12/2008 Hurlock, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facilify Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVA Due to (or as a consequence of): COTONARY ATTERY INSUFFICIENCY Sequentially list conditions that you all you immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HIPELTENSION DIAbetes 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death' 2 No 2 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23a or 28a-f show

"natural",

Hygiene.

Health and Mental Hyginem 27 is marked other

permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau

the Medical Examiner must be notified at

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Funeral

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Examiner

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

burial-tran physician the burial attending p signed by the a page 2 should be been has certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

the Hospital or Attending Physician:

Physician/Medical ۵ Completed Be Certification: To

23b. Was decedent pregnant 9 ☐ Unknowr

1 Yes 2 No 27. Manner of Death

4 \ Homicide

5 Pending investigation 1 Natural 2 Accident 3 Suicide 6 Could not be

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28b. Time of

29b, Signature and tit

23154

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAN KOVICK

and manner stated.

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State Registrar

Medical

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	Funeral	Г	Social Security Number 6. Sec.		. last birthday)	If Under 1 Year Months Days	If Under 24 H	in. (Month, Day,	Year) 9. Bir	thplace (State or Foreign
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36	s after , or Ite	by Fu	1 Never Married 2 Married	1 □ Yes 2 No If Yes, Give		1 Tes, specify Cuba 1 □ Yes 2 No	Specify:	eno mican, etc.)	Black, Whit	
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Jore	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cren	sition (Name of natory or other place	(a)		Oc. Location - City or	
	permit. Pag Department Important: f any injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			JCE . Name and Addres		108 pool 1	MLL KIU	er, NC
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89	artifical ing phy s as th	Medi	fF FEMALE:							
Вох	leath certific attending p	ian/I	23b. Was decedent pregnant	3c. ff yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	al death 3 🗆	Ectopic pregnancy			23d. Date of de	ivery Day Year
O	che the	Physician/Me	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4□ Pregnant at time of d 9□ Unknown	death 5□	Other (specify)				-1,
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0 0	of the state of th		27. Manner of Death 1 Naturat 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how		
Division of Vital Records,	Attending Prysician: r death. ector: After this certific by the funeral director.	ficat	Accident investigation  3 Suicide 6 Could not be	28e. Place of Injury - At he	Ome farm stre		Yes 2 □ No	28f Location /Stre	et and Number or Ru	Imil Pouto Number
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	or the nospinal or Attending Prysician; within the Yours effect death. To the Euheral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina	owledge, death ation and/or inv	occurred at the time estigation, in my or	ne, date and place pinion, death oc	ce, and due to the cau	ise(s) and manner as e and place, and due	stated. to the cause(s)
	within To the comple	Mec	29b. Signature and title of certifier	and manner stated.	,	29c. License	number	29	d. Date signed (Mont	
			1 7/2			330	0660		09/11/20	08
K.	t		30. Name and address of person who cor	mpleted cause of death (Item	n 23a) (Type, F	Print)	No. 110	, ROCKVILI	= NAL O	0850
	Sta	te	31. Date fifed (Month, Day, Year)	32. Heorstrar's Signa	iture 🎉	Acad s	DKIVE	, NOCKVILL	5 IMD of	0850
	Registra		SEP 2 3 2	2008 Lienzana	Sir fo	A Committee of the Comm				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** C 2008 Alexander hie Jenkins ptembe /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner jalbot Memoria to spita aston 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 36 1 M 2□ F Months Days Hours Min. Yrs. Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits is marked other than "natural", or items 23a or 28a-f show death with the Man 1 ØYes 2 □ No Director 0160 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2160 by Funeral USA OOK 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 PNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 12 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Mangonee. Elementary/Secondary (0-12) College (1-4or 5+) Manufactur achine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Jenkins Alexander iane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cambridge Stone Boundary Alexander Jenkins Archie 406 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Trappe, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Paradis 22. Name and Address I Facility HENRY FUNERAL HOME, 510 Washington St. Ca 21. Signature of Funeral Service Licensee Washington St. Cambridge, MD. 21613 23a. Patr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Acute Respiratory
Due to (or as a consequence of): use as the burial-tran Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria psi's Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Was an autopsy performed? Hyponatremia 1 □ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
Natural
Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 2008

DHMH 17 Rev 1/2001

State Registrar Michae

31 Date filed (Month

Day, Year)

S. Washing

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Raistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 6, 2008 3:30/A M Harriett Hammond Jarzynski 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Apr 23, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. Massachus etts 1 □ M 2 🖾 F 032-16-7036 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Montgomery Germantown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20874 USA 13611 Monarch Vista Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 📈 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Office Worker 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Elizabeth M. Hammond (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John B. Jeffrey/son <u>13611 Monarch Vista Dr. Germantown, MD</u> 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 09/08/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signate of Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 📉 No lical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

Director

Funeral

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Completed

Be

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MD

ed other than "natural", or items 23a or 28a-f show event, the Medical Evanciae must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Its My once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and burial-tran attending physician signed by the attendir be detached for use signed by has certificate

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician:

Examine Physician/Medical þ Completed Be 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil Certification:

on bice	
5	
2	25. Was case referred to med examiner? 1 ☐ Yes 2 ☐ No

29a. Certifier

Medical

State

Registrar

27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident

6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier J. Koudtehou

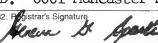
29c. License number D0063748 29d. Date signed (Month, Day, Year) September 6, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

and manner stated.

31. Date filed (Month, Day, Year)

SEP 0 9 2008



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITM#23e&26.perPHYS.G883.9/23/08.WS
State of Maryland / Department of Health and Merital Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 11, 2008 Month **Physician** Douglas Virgil September Johnson 2:21 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2500 Barksdale Rd. Elkton Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | June 29, 1933 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1**X**|M 2□ F 75 Tennessee Director 412-48-0063 Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director MD 1 Tyes 2K No Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 Barksdale Rd. 21921 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1▼ Yes 2□ No If Yes, Give Year or Dates: Korean 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Military U.S. Army is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental F Be Virgil Johnson Lucille Henson injury or other traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once, Billie Jo Kirby (Niece) 2500 Barksdale Rd. Elkton, MD 21921 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R. A. Ferris & Co. 9/12/08 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 ustenting 23a. Part1, Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed 事件の 10mgと Division or Vital Records, P.O. Box 68760 会 attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <del>ag(N</del>o 1 🙀 Yes 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 👿 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 0 Kher (Specify) funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural To the Hospna... within 24 hours after death.
To the Funeral Director: Aftramately filled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) MT dimonson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 23 Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

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	ı	1 - For State Registrar	State of N	Marylan		artment <i>tificate</i>				lental H	ygiene Reg. No		8	301	+7
Physicia /Medic		1. Decedent's Name <i>(First, Middle</i> Anne	D.		Lydon					2. Date of D Month Septemb	Da	ay Ye		3. Time of [7:30 A	Death M
Examin		4a. Facility Name (If not institution, Southern Maryland	0	er)		4b. City, T	ton	ocation	of Death	•	40	County of D	eath		
Funeral Director		5. Social Security Number 163–16–6398 Usual Residence of Decedent	6. Sex 7.7 1 □ M 2 <b>X</b> XF	Age (In yrs. I	a <i>st birthday)</i> Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D June 1,	irth Pay, <i>Year)</i> 1917	9. Pe	Countr	ce (State or 1vania	Foreign
2 should be filed within 72 hours after death with the Manyland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Everties in unit to indified a	al Director	10a. State 10b. County	George's	10c. City, Town or Location Ft. Washington 10f. Zip 2074							10g. Ci	tizen of What		I. Inside City 1 □Yes	<b>'</b>
hours after dea atural", or items	ed by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced  15. Decedent	If Yes, Give Year or Dates	s? <b>X</b> No	If	Vas Decede Yes, specif	<b>KN</b> No	Specify:			14. Race - A Black, W Specify:	/hite, etc	White	<u>;</u>	
ed within 72 ygiene. her than "na t, the wedi	Completed	(Specify only highest 12)	grade completed) College (1-40	r 5+)	(Give R life. D Public	kind of work OO NOT use	done du retired)	ring mos	t of worki	ng		ederal (		,	
nould be fill d Mental H narked oth natic even	To Be	•	Verano						Mary	(First, Middle Barle	etta	<u> </u>			
1 and Health em 27 ther t		19a. Informant's Name/Relationsh Thomas J. Lydon 20a. Method of Disposition	_	20h Pl	3208 C	alydon	Court	t Ft	. Wast	al Route Numb nington, late	Mary.		20744		
t. Page rtment rtant: II		1XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of uneral Service L	ecify)	e i	ace of Dispos metery, crem Surrecti	on Ceme	etery	(	09/11/		Clir	nton, Ma	ryla	nd	
permi Depa Impo any ir once.	5 0	23a. Part Linter the disease, or o	KY	- 1 1 - 1 - 1	61	60 Oxor	n Hill	L Road	d Oxor	Hill, N	Maryla		745	pproximate	
Physician /Medical Examiner	ner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	line Is a consequence as a consequence	ence of):	ήc				SCUL.		NSS	Ir	iterval Betw priset and Do	een eath
dhysicia	dical Exa	cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	s a conseque	ence of):		-								
Trips definition for the raw requires that the default certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □								Month					ar
en signed	2	Part II. Other significant condition	s contributing to death	but not resul	ting in the und	derlying cau	se given	in Part I.			tobacco i Yes 2	use contribute		cause of de ly 4 ☐ Ur	
nysician; ine law r his certificate has be I director, page 2 sh	e Completed	25. Was case referred to medical								1 □ Yes	psy ormed? 2 No	prior death	to comp	y findings av letion of cau □No	ailable
r this cer ral direct	B 일	examiner? 1 ☐ Yes 2 KNo  27. Manner of Death	Hospital: 1 Impai		R/Outpatient 28b. Time of		Other:	4 □ Nu	rsing Hon	(Check only one 5 ☐ Res	idence		Specify)		
To the nospital or Attending Private National States of the Funeral Director: After the completely filled in by the funeral	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	(Month, D	lay, Year)	Injury ne, farm, stree	М		s 2 □1	No	8d. Describe 8f. Location ( City or To	Street an	nd Number or	Rural F	oute Numbe	9 <i>r</i> ,
ne nospin in 24 hour he Funers pletely fills	edical (	29a. Certifier  (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best taminer: On the basis and manners	of examination	ledge, death on and/or inve	occurred at	the time	, date an nion, dea	d place, a	and due to the	cause(s date and	) and manne d place, and d	r as stat due to th	ed. e cause(s)	
e # e 5	∑	29b. Signature and title of certifier		77			icense n		74	5		te signed (Mo			208
State		30. Name and address of person will be a second of the sec	no completed cause of MAN (	death (Item : 2070 trar's Signatu	23a) (Type, Pi	) L/A	36	(8)	UTE,	in u	JAC	DONE	M	dZ	XX
Registra	r	SEP 1 0 ZUUO	Com or	trar's Signatu	4R)										

				Type or Prin			delible lnk artment of h						
			1 - For State Registrar  1. Decedent's Name (First, Middle, La:			•	rtificate of		2. Date of D	Reg. No.		3 Time of Death	
	Physicia /Medic		Betty Jane LAPOLE	,					Month Sept.	Month Day Year 6:02 a. M			
	Examin		4a. Facility Name (If not institution, giv 145 King Street,		nior	Care	4b. City, Town, o		ath	4c. County of Death  Washington			
I	Funeral Director		5. Social Security Number 6. S 215-20-9502			last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		Day, Year)	9. Birti Co. M.	nplace <i>(St</i> ate or Foreign untry) aryland	
	land ow		Usual Residence of Decedent  10a. State 10b. County	<del></del>	10c. City, Town or Location							10d. Inside City Limits	
	e Mary	ctor	Maryland Washir	ngton		Hag	erstown					1XYes 2 No	
	h with the	Funeral Directo	10e. Street and Number 145 King Street,	C.J.'s Se	nior	Care	10f. Zip Code 21740	)			zen of What Co J <b>SA</b>	untry?	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heatht and Mental Hygiene. If Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it as feeden Examinations to diffied at	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 □Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 □ Yes 2 🖼 No		(Specify Yes or N erto Rican, etc.)	lo-	14. Race - Amer Black, White Specify:		
215-0036	"natura	Be Completed	15. Decedent's Ed (Specify only highest gra	ide completed)		16a. Dece	edent's Usual Occup kind of work done DO NOT use retire	pation during most of w	orking	16b. Kii	nd of Business/I	Industry	
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D .	be filed ntal Hyg ed othe event,	Be C	17. Father's Name (First, Middle, Last,						ame (First, Middl		Surname)		
Maryland	should band Men s marker umatic	우	John William Nav			T 10h Maili	ina Address (Street		May Wea		r Town State 7	Zin Codo)	
<u>a</u>	and 2 shealth and n 27 is n		19a. Informant's Name/Relationship ( Sandra K. Hull –	**			Main Ave						
Je,	ss 1 ar of Hea litem :		20a. Method of Disposition		20b. F		osition (Name of matory or other pla		Date		ocation - City or		
Ĕ	Pages ment of ant: If It		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			gersto	wn Cremat	ory 9/	12/08	Hag	gerstown	, Maryland	
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~ F	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each in	Mix	1200	mutar	anes	I, em	mes	lab	Onset and Death	
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		Be Co	25. Was case referred to medical			_		26. Place of D	1 ☐ Yes leath (Check only	2 2 1/40	1 ☐ Yes	2 □No	
	G io	To B	examiner? 1 ☐ Yes 2 🗗 No				III OLI DOA		Home 5□ Re		6 COther (Spe	ises tool Leve	
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בֿ	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Pl	hysician: To the best	of my kno	wledge, dea	th occurred at the t	time, date and pla	ace, and due to the	ne cause(s	) and manner a	s stated.	
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	Within Common	Ž	29b. Signature and title of certifier	10	10			se number		29d. Dat	te signed (Mont	h, Day, Year)	
)	OPP		30 Name and address of person who		death (Iten	n 23a) (Tvpe			1	· ·			
	4		MASSOUD B. A	LIZADEA	, MA	24	0 Freder	ichst.	1 tager.	3 tou	Un HD	21740	
	Sta Registr		30. Name and address of person who MASSOUD B. A 31. Date filed (Month, Day, Year)  SEP 1 2 2	ONP 32. Project	ar's Signa	iture	fort						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LEVY Cecile 7:00 P. M 2008 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 X F June 10, 1935 Syracuse, N.Y. Director 225-40-9036 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Neddes Exercited must be notified at 28a-f show Rockville 1 Yes 2 No Montgomery MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20852 #905 6111 Montrose Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify. White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Publishing Customer Relations 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wolf Gertrude Weinberg **Emanuel** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 Montrose Rd., #905, Rockville, MD. 20852 19a. Informant's Name/Relationship (Type. Print) / spouse Sidney Levy 20b. Place of Disposition (Name of cemetery, crematory or other place)
t. Lebanon Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date Sept.10,2008 Adelphi, MD. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Dcenses 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2√2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 2 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) allan 3 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SEP 0 9

DHMH 17 Rev 1/2001

MD.

327 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 1426 P Illam Leroy Lake 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner Maryland Medical Center Baltmore Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 17, 1953 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security **Funeral** 216-56-0378 1 M 2 F Months Days Hours Min. Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 PYes 2 □ No **Funeral Director** Dorchest 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 PNo Specify. Black ş 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing nning Machine Technician permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item Z7 is marked other any injury or other trainment. 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) ဂ္ဂ aKe ia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Road ambri Janice Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State Easton, MD Woodlawn Mem, Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOME, P. 14 ENRY FUNERAL HOME, P. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD. 21613 Cam Approximate Interval Between Onset and Death Immediate Cause (Final Sarcoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Ulnknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown 1 🗌 Yes filled in by the funeral director, page 2 should Completed peen a 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Ño 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Feath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital thin 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within To the

DHMH 17 Rev 1/2001

State Registrar

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29b. Signature and title of certifier

30. Name and address of person

Gregory

Small

MD

ompleted cause of death (Item 23a) (Type, Print) 22

gistrar's Signature

29c. License number

9000

Greene Street Baltimore,

29d. Date signed (Month, Day, Year)

08-07034
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		- For State Registrar		Cert	ificate o	Death					g. No.	
Physicia	ın/	1. Decedent's Name (First, Middle	,Last)							<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death 1127 hrs
edical Exami		Stephen	Michael	Long				-		September	14, 2008 4c. County of I	
		4a. Facility Name (if not institution 8192 Main Street	, give street and number	er)		4b. City, Tov Ellicott		cation of	Death .	1 -	Howard	
Funeral Director		5. Social Security Number 220–21–4068	6. Sex 7. A	Age (In yrs. las 24	st birthday) Yrs	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.		1, 1984	Birthplace (State or Forei Country)  Maryland
w any	Ī	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Local					2		10d. Inside City Limit
th the Maryland 23a or 28a-f show notified at once.		Maryland Frede  10e. Street and Number	erick		Frede	rick 10f. Zip C	ode			10	g. Citizen of What	Country?
h the M 3a or 2	ă	8303 Brookmere			- 1		702		0.10			States American Indian, Black,
eath wit items 2 ust be n	uneral	11. Marital Status 1 X Never Married 2 Ma	rried 12. Was Decede Armed Force 1 Yes			es Decedent es, specify				ecify Yes or No- Rican, etc.)	White,	
fter d	by Fi	3 Widowed 4 Divo	orced If Yes, Give Year	22 110	1	Yes 2	No	specify:			Specify:	White
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed b	15. Decedent's Education (Spec Elementary/Secondary (0-12)		, , ,	16a. Deceder during n	nt's Usual On nost of worki					16b. Kind of Busin	ness/Industry
03( ithin ar tha	E		4		ΙT	Techn					Comp	uter
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Michael Josep					18			(First, Middle, N e Ann F	daiden Surname)	
21 bould I d Mer is mar tic ev		19a. Informant's Name/Relationsh				•	,				ber, City or Town,	
MD d 2 shoulth and m 27 is		Michelle A. Rah	man / Moth						<u>d.</u>			1and 21702
Baltimore, permit. Pages I an Department of Hea important: If iter		20a. Method of Disposition  1 X Burial 2 Cremation			Ob. Place of Disposition (Name of cemetery, crematory or other place)  Resthaven Mem. Gardens 19, 2008 Frederick, Maryland							
Itin ii. Pa urtmer ortan	1	4 Donation 5 Other Sp. 21. Signature of Funeral Service		Kes	22.	Name and A	ddress	of Facility	Sta	uffer F	uneral H	omes, P.A.
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep	8	Delamr J. Fent		per DV	R   16	21 Op	ossu	mtow	n P	ike Fr	ederick,	Maryland 217
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that caus on each line.	sed the death.	Do not enter	the mode of	dying, s	uch as ca	ardiac o	r respiratory arre	est, shock, or hear	t Approximate Inter- Between Onset at Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. <u>Cardia</u> Due to (or as a co									
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b.  Due to (or as a co					77				
recuted n and - transit	/Medical Exa	events resulting in death) Last	d.		,							

Division of Vital Records, P.O. Box 68

Division of Vital Records, P.O. Box 68

To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.

Within 24 hours after death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as

past 12 months? Physician 4 Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? ✔ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA Inpatient 2 Medical Certification: To 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29h Signature and title of certifie O.C.M.E. September 15, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

prior to completion of cause of death?

2 No

1 🗸 Yes

Assistant Medical Examiner Laron Locke MD.

2008

ORIGINAL

State

Registrar

Scalled F.H.

31. Date filed (Month, Day, Year) SEP 1 8

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0245A M Lankford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomics PANINGULA 1006IDNIKUMEDICKLOBUTER SALISBUR If Under 1 Year Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**X** M 2 □ F 255-44-5988 7/3/1931 **Director** Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f shoo any injury or other traumatic event, in a leaffect Examination and the configuration. 1 D¥Yes 2 □ No Director Salisbury Wicomico Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 502S. Division St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2 XNo 1 Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2 🎇 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office machines owner 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Maggie Pearson Lola Lorenzo Lankford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 611 N. Pinehurst Ave., Salisbury, MD 21801 Joanne L. Grant/daughter Baltimore, 20b. Place of Disposition (Name of Springhilly Methor) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/10/08 Hebron, MD 4 □ Donation 5 □ Other (Specify) Gardens Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 W Monoporo CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CANCER **Physician** LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTASIS BRAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transi and resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Box 68760. pe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? I ☐ Live birth 2 ☐ Fetal death 3 Ctopic pregnancy Month Day Year ☐Yes 2☐No o. 9 Unknown signed by ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 □No 2 🗆 No 1 □Yes of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 TUNO 2 ER/Outpatient 3 DOA Inpatient Certification: To this 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Fafter death. Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

To the I to the Complete Compl

Dwen lankford

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

New Polys J. (Du M WORD ST.,

106 MUFORD ST, # 504B, MD 21804

31. Date filed (Month, Day, Year)

SEP 0 9 2008

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🖓 🗍 🧍 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Year **Physician** Eleanor R. McLendon 26, 2008 8:32 p August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday, 6 Sex **Funeral** Year) Months 1 □ M 2 X F 578-09-5932 89 16, 1918 Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amount in the montant of the manual cevent, the Wednal Ever next be notified at once. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3700 International Drive, #111 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∑XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify White 2 **X**XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Medical Instruments 17. Father's Name (First, Middle. Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alonzo Randolph Rowles Elizabeth Root ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) C. Keith McLendon/Son 24767 North 117th Street, Scottsdale, AZ 85255 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Metropolitan Crematory Aug. 3 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 31, Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Pneumonia unknown /Medical Due to (or as a consequence of): Examiner Dehydration unknown Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-tra resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown signed by tl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🏝 No 2 🗆 No 1 ☐ Yes nours after death.

neral Director: After this certificat
y filled in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XINo 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 🔼 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Hospital or Attending Physician: The law requires that the cleath certificate be executed P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a. Certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier hemo. ±, 29c. License number 00062999 29d. Date signed (Month, Day, Year) August 28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Petek Domez, MD 8600 Old Georgetown Road, Bethesda, MD 20814

State Registrar

Medical

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** MENDE 12.37 PM JOHN 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DORCHES GENERAL CAMBRIDGE TER DORCHESTER HUSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X**] M 2□ F Maryland Director 58 11, 1950 216-56-1903 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylanc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinational be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State Yes 2 No Cambridge Director Dorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21613 USA 127 Vue de L'eau St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: white <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) security guard hospital 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellen Gray Eric Mende Jr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21673 brother 4080 Main St., Trappe, MD Eric Mende III 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/5/08 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 10. 15 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NEUMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE RENAL Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Citie to (or as a nunsealtrence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed CARDIAC ARREST burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the burial ORGAN FAILURE Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ OBESIT 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 2 ☐ Accident 5 Pending investigation after death.

I Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 67465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abul Foyez Arifuddowla, M.D. 300 BYRN STREET, CAMBRIDGE

Registrar

State

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** September 4, 2008 4:30 P M Andrew Matthews Robert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's 8. Date of Birth (Month, Day, Sept 23, 5. Social Security Number Sex 1Å M 2□ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Days Months Hours Min. 142-28-8770 Director 70 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Madical Examination is notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9155 Bourbon Street #R 20723 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1X Yes 2 □ No If Yes, Give Black, White, etc. (unk) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 <u>Maintenance Supervisor</u> State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Howard Matthews Dorothy Mae Kee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9728 Whiskey Run Laurel, MD 20723 Susan L. Gonzalez/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 09/05/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Sing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Arrhythmia Sequentially list conditions, if any teaching to in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Sepsis Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ospital or Attending Physiclan: Ti hours after death. uneral Director: After this certificate ly filled in by the funeral director, pa 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mijaled m D59556

Registrar DHMH 17 Rev 1/2001

State

11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

SEP 0 9

Humera Mujahid, M.D. 7300 Van Dusen Rd. Laurel, MD 20707 32. Resistrar's Signature

September 4, 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:19 PM 09 08-2008 Eloise Wright Morison /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbur Wicomico TheLake Coastal Hospice at If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months 1 □ M 2 🖾 F Maryland 29, 1922 212-32-1674 Director Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or rother traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Director MD Wicomico Delmar 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21875 26344 Delmar Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify Specify. white ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amy Ellis George E. Wright ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21875 26360 Delmar Road Delmar, MD Ridgely Morison (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Crematory of Delmarva 09-09-2008 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee 19940 Delmar, DE 13 East Grove Street Approximate Interval Between Onset and Death e, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the diseal shock, or heart silure. Immediate Cause (Final disease or condition resulting in death) DRSRASE CORONARY Physician /Medical Due to (or as a consequence of): **Examiner** ACUTR MYO CARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the for use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
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DHMH 17 Rev 1/2001

		-	- StateAmended itmes#7&1	9a,WCHD,SL	U Cer	tificate of L	Death			Reg. No.		
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Cynthia Kay	Marshall					2. Date of Dea Month Septen	Day	5, 2008	3. Time of Death 3:15 p <sup>M</sup>
	/Medic	al	4a. Facility Name (If not institution, give street a			4b. City, Town, or	Location o	f Death	Septen		ounty of Death	3:13 p
	Examin	er	1311-D Middleneck Di	rive		Salis	bury			Wi	comico	
	Funeral		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birl (Month, Da		Coun	2'
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	with th	Funeral Director	10e. Street and Number 1311-D Middleneck Dr	rive		10f. Zip Code 21804	Į.			USA		uy:
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36	rs after	by Fu	1 X Never Married 2 ☐ Married 1 X If Y	ned Forces?  Yes 2 □ No es, Give A <b>rmy</b> ar or Dates:	7	1∐Yes 2∭2No	Specify:			S	pecify: wh	
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<u>a</u>	lld be fental fental rked o	To Be	Clifford P. Marshal	L			Est	her .	A. Smit	:h		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any irrury or other traumatic event, the Modical Extensional to recitified at once.		19a. Informant's Name/Relationship (Type. Prinsheila E. Lydon/daug.	nter	19b. Mailir 131	ng Address (Street 1–D Middl	and Numbe Leneck	er or Rura Dr.	Route Numb	er, City or T sbury	rown, State, Zip , MD 21	9 Code) 8 <b>04</b>
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Baltimore,	permit. Depart Import any in		Stimilare H Son Sovice Licensee	0000	22	Holloway 501 Snow	ss of Facilit Funer Hill	al H	ome Pro	ofess:	ional As MD 218	ssociation 04
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uc	ding Phi J. After thi funeral	ion	1 Natural 5 □ Pending	i. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wo	iry at rk? ]Yes 2 □		28d. Describe	now injury	occurred	
Visio	or Attendatter death	Certification:	2 DAGGGGTT	. Place of Injury - At I building, etc. (Spec	nome, farm, st				28f. Location	(Street and wn, State)	Number or Rui	ral Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical	29a. Certifier (Check only one) Certifying Physician 2 Medical Examiner: Cartifying o the best of my kr In the basis of examir Ind manner stated.	nowledge, dea nation and/or i	th occurred at the t nvestigation, in my	time, date a opinion, de	nd place, ath occur	and due to th red at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	7	22 2		se number				e signed (Month	
	NIN	i	1 776 /		MO	0	306	90		5cp	t. 8,	2008
	DI F	J	30. Name and address of person who complet		em 23a) (Type	Print)	Corra	11 5	+ 5	1/2	bur	MO
u	St	ate	31. Date filed (Month, Day, Year)	32. P gistrar's Sign	nature			, ,	,	/ . 3	7	
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Cyndi McCready/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 9/8/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD Thornow Hill Rd., Salisbury, MD 21804 gnature of Funeral Service Licensee Compson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HRONCE 0135 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 men 1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknowh as been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performe 1 □Yes 2 Ano 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OOX 1733 Specis Burguer 21802 DASTAL

Registrar DHMH 17 Rev 1/2001

State

Win

31, Date filed (Month, Day, Year)

h

SEP 0 8

32. Regitrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9/3/2008 **Physician** 11pm м Annita E. Owe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 872471927 1 □ M 2XX Germany 110-28-4267 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinor must be mutified at once. 1 ☐ Yes 2X XNo Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21046 USA 8483 Kings Meade Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 □Yes 2√2No 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 🍇 XNo If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homes Domestic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrud Winterhof Ernst Havemaester ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Columbia, MD 21046 8483 Kings Meade Way Manfred Owe Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/06/2008 Glen Burnie, MD Atlantic Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 17 Annapolis, MD 21401 12 Ridgely Ave. 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) M40 /Medical Due #: (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of: the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No signed by the a o. 9 Unknown ٦. The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 00 VO 515 24a. Was an has page 2 certificate 2 No 1 ☐ Yes 1 ☐ Yes the Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 14 1 ☐ Yes Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death Injury (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number so of person who completed cause of death (Item 23a) (Type, Print) Frank 31. Date filed (Month, Day, Year) State SEP 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 9 2008 **Physician** Sarah Mary Pryor 2:55 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Sligo Creek Nursing Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 8-4- 1918 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 ☐ M 2 X F 90 552-30-6547 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show the Medical Examiner must be notified at MD. Prince Georges Hyattville 1 Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 6020 Sargent Rd. 20782 Funerai filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural', or 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Housekeeper Private permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic event, Item 2006. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nannie Armstead Lewis Roberson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gene Gilstrap (Son) 5045 12th St. N.E. Wash. D.C. 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State Landover MD. Harmony Mem, 1 Cem. 9-11- 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service Licenses Francis 908 Kennedy St. N.W. Wash. D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athanosclarotic **Physician** Cardiovascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inflinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) led by the attending physician detached for use as the buria Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 11/10 25. Was case referred to managed examiner? Be 26. Place of Death (Check only one)

Division of Vital Records, P.O. Box 68760

this certificate has Hospital or Attanding Physician: 24 hours efter death. Funeral Director: Atter this certification by the funeral director. 24 hours e within 2

29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uniesse

5 Pending investigation

6 □ Could not be

1 Yes 2 No 27. Manner Jeath

1 Matural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29c. License number 00060100

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

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Other: 4 Trursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

BLVD East 32. Registrar's Signa

State Registrar

Certification:

DHMH 17 Rev 1/2001

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:33P M 06, 2008 Anna B. Pang Sept. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days New Jersey 80 Jan 20, 1928 150-20-5596 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the "nedsal Examination up to content that the medical Examination. 1 X Yes 2 No Wheaton MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 11901 Georgia Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 1 No Specify: white <u>Ş</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tea Iselo James Basile ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 4954 Ilchester Pt. Court, Ellicott City, MD 21043 Maryann Foxwell- Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Comfort Cemetery 09/12/2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Demaine Funeral Home 520 S. Washington St, Alexandria, VA 22314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unknown Peripheral Vascular Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director name? Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 X No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, ischemic left foot, bilateral pleural effusion, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? malnutrition, diabetes 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 🖾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title D0060117 09/08/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd, Bethesda, MD 20814 Eric J. Park, MD 31. Date filed (Month, Day, Year) SEP 1 0 2008 32. Registrar's Signatu State Registrar

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Pang, Anna

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r<sup>Day</sup>5, 2008 **Physician** September 6:40 Barbara A. Powell AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House-Montgomery Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F 217-42-2112 64 Yrs. July 21, 1944 Washington, DC Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a fledical Examination and borodified at once. 1 ☐ Yes 2 X No Gaithersburg Maryland Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 United States 134 Thurgood Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 😿 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2√∑No Specify Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Accountant/Auditor Accounting 17. Father's Name (First, Middle, Last)
Bernard E. Powell 18. Mother's Name (First, Middle, Maiden Surname) Sue M. Melrose ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10314 Ridgemoor Dr., Silver Spring, MD 20901 Barbara R. Holloman (Executrix) 20b. Place of Disposition (Name of cemetery, crematory or other place of Heaven Cemetery 20c. Location - City or Town, State September 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10, 2008 4 Donation 5 Other (Specify) Silver Spring, MD 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral Service License 10 E. Deer Park Drive, Gaithersburg, MD 20877 1 RACK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heary failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Pancreatic Cancer Physician /Medical Due to (or as a consequence of): Examiner Hypothyroidism Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) □Yes been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:  $_{4\,\square\,\,\text{Nursing Home}}$  5  $\square\,\,\text{Residence}$  6 otin Other (Specify) Hospice1 ∐Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10

31. Date filed (Month, Day, Year)

SEP 0 9

29b. Signature and title of certifier

Kouatehou

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

State

Registrar

29c. License number

200 63 748

29d. Date signed (Month, Day, Year)

September 5, 2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dav Year Month **Physician** Letitia Passig Diane 2008 6:20 p September 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21821 Glendalough Road Laytonsville Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 3 K Director 1934 Illinois 353-28-1814 73 Oct. 20, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show event, the Medical Examiner hust be notified at Director 1 ☐ Yes 2 ☐ No Maryland Montgomery Laytonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with ō 23a 21821 Glendalough Road 20882 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 'natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withir Health and Mental Hygiene. em 27 is marked other than 4 Administrator Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Raleigh Oralle Randell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra Richard E. Passig/Husband 21821 Glendalough Road, Laytonsville, MD 20882 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 🙀 Removal from State Sept. 12, Mount Emblem Cemetery 4 ☐ Donation 5 ☐ Other (Specify) C 2008 Elmhurst, Illinois 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Cardiac Arrhythmia minutes /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease years Sequentially list conditions Per Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Exami Hyperlipidemia years and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. ed by the detached f 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 Tes 2 No 3 Probably 4 Unknown Bicuspid Aortic Valve Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an law has autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2K No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier \*Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D21392 September 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia D. Kellogg, MD 1201 Sewen Locks Road, #111, Rockville, MD 20854 31. Date filed (Month, Day, Year) 32. Restrar's Signature State 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Bhaskar ÖÖ Kuberbhai Patel 2008 04 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Wicomic Hospice at the Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months 146-70-7700 67 8/31/1941 India **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits sa or 28a-f show t be notified at 10a. State 10b. County 1 XYes 2 No Director Wicomico Delmar Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9129 Club House Drive 21875 USA ms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or Items the Medical Examiner mu 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Hindu Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 5 Dep rment of Health and Mental Hygiene. Important: If item 27 is marked other than any njury or other traumatic event, the Medican. Elementary/Secondary (0-12) College (1-4or 5+) manager hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Surajben K. Patel Kuberbhai D. Patel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrudula Patel/wife 9129 Club House Dr., Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 9/6/08 Salisbury, MD nature of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association and 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY **Physician** END STAGR /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) CORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical for use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ DVo 24a. Was an autopsy performed? certificate 1⊟ Yes 2 . Me **Division or Vital** Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 thpatient 2 ER/Outpatient 3 DOA 2 this completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Magner of Death 28a. Date of Injury 28c. Injury at Work? After t Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After (Month, Day Year) \*\* Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 🗌 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

7-21

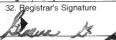
DHMH 17 Rev 1/2001

State

Registrar SEP 0 8 2008

31. Date filed (Month, Day, Year)

GHUAM



ONSTAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



00058410

Po Box 1733 stus Buyuno 21802

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	rylan	-			ealth ai	nd Mer		giene Reg. No	7000	304	96
	Physici /Medic		1. Decedent's Name (First, Middle, La	30) Russell	\						Date of Dea Month	ath Da	y Year 4 ZOO	3. Time of 234	
	Examin		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location of	Death	n- 0	4c	. County of Dea	th	
			Hachorasse	Norsin		4 6 lab 1	5a	lis	If Under 2	4	フラ	7	) roow	NCO	· [
П	Funeral Director		5. Social Security Number 6. S 215-58-5341	7. Age 57 57		ast birthday) Yrs.	Months		Hours	Min.	Date of Birt (Month, Da /10/1	v. Year)	9. BI	thplace (State or ountry) ryland	roreign
			Usual Residence of Decedent								710/1		110	Lyzana	
	how		10a. State 10b. County			, Town or Loc								10d. Inside Cit	
	8a-f	Director	Maryland Wicomio	20	Sa	lisbur	_							1 🔀 Yes	2 U NO
	within 72 hours after death with the Marylend ene. Then "natural", or items 23a or 28a-f ehow he digat Executive mast be notified at	Dire	10e. Street and Number 1417 Old Ocean	City Pood			10f. Zip	Code 2180	1				tizen of What C USA	ountry?	
	leath	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.	S. 13. V	Vas Deced	dent of Hi	spanic Origi	in? (Specify	Yes or No		14. Race - Am	encan Indian,	
(0	r iten	Fun	1 Never Married 2 Married	Armed Forces? 1 Yes 2 XNo		If	Yes, spec	cify Cuba	n, Mexican,	Puerto Rica	ın, etc.)		Black, Wh	te, etc.	
21215-0036	raff, o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			Yes	21 <b>2</b> 1 NO	Specify:				Specify:	white	
5-0	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced (Give)		rk done c	turina most o	of working		16b. K	and of Business	/Industry	
12	within ane. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+	.)		tric		,			C	onstruc	tion	
0 0	filed Hygi other		17. Father's Name (First, Middle, Last,	)		0100	.02.20.		18. Mother	's Name (Fi	rst, Middle,			CION	
au	Ald be Alental rked tic ev	To Be	Stephen E. Russe	ell					Mary	7 E. H	atton	l			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Healin and Menth Hygiene. Deportment of Healin and Menth Hygiene. Preparate 1 is marked other than "natural; or tieme 21a or 28a-1 show any injury or other traumatic event, the Medical Examination as the nutitied at once.		19a. Informant's Name/Relationship ( Charles A. Russe										or Town, State,		
ē,	s 1 ar		20a. Method of Disposition			lace of Dispos emetery, crem			e)	Date		20c. L	ocation - City o	Town, State	
Ē	Page nent can ant: if ary or		1  Burial 2  Cremation 3  C 4  Donation 5  Other (Specif		Spr	inghil ardens	1 Mer			9/9/08		Не	ebron,	MD	
Baltimore,	permit. Depertr importu		21. Signature of Funeral Service Licer	nsee	9	22 H		d Addres Way I now I	i unera Hill R	il Hom	e Pro alisb	fes	sional . , MD 21	Associat 304	ion
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death	. Do not ente	er the mod	le of dyin	g, such as c	ardiac or re	spiratory ar	rrest,		Approximate Interval Bety	veen
	Physician		Immediate Cause (Final disease or condition	a. It	unt	nghon'	s c	hon	er					209c	ans
	/Medical Examiner		resulting in death)	Due to (or as a											
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c ·	te be executed ysicien and e burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as a	consequ	uence of):									
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P.O. Box	The law requires thet the death certifica site has been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal	death 3 🗌	Ectopic pr						23d. Date of de Month		'ear
o.	the e	sic	1 Yes 2 No	4☐ Pregnant at ti 9☐ Unknown	me of de	eath 5	Other (sp	ecify)						<i>5</i> <b>2</b> ,	
٥.	thet the	P.	Part II. Other significant conditions of	contributing to death but	not resu	Itting in the un	iderlying c	ause give	en in Part I.		23e. Did to	obacco	use contribute	o the cause of de	eath?
Division of Vital Records,	uires Isign Id be	d by									1 🗆 Y	Yes 2	□No 3□F	robably 4 □	nknown
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ta	icien: Th certificete rector, pag	Bec	25. Was case referred to medical						26. Place o	of Death (C			1010	20140	
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ū	Ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury		8c. Injury Work			Describe h	now inju	ry occurred		
Sign	or Attending Physicien: after death. Director: After this certifice in by the funeral director, f	cat	2 Accident investigation 3 Suicide 6 Could not b		y - At ho	mo farm etro	M factor		res 2 □ No		Location (	Stroot 20	ad Number or F	ural Route Numi	hor
<u>&gt;</u>	al or A after i Direct d in by	Certification:	4 Homicide determined	building, etc.	(Specify	<i>')</i>	et, factory	, onica		201.	City or Tov			Drai i lobie i voini	<i>J</i> 61,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of e and manner state	examinat	wledge, death ion and/or inv	occurred estigation	at the tim	e, date and pinion, death	place, and occurred a	due to the	cause(s date an	) and manner a d place, and du	s stated. e to the cause(s)	
	within To th compl	Me	29b. Signature and title of certifier				290	c. License	number				te signed (Mor		
	0 01		I made rely					0051	1359			Sep	tenter	5/5 200	8
	かかり		30. Name and address of person who	completed cause of dea	ath (Item	23а) (Туре, Р	Print)								
			DR. USHA NATES	AN 1415	5.1	) 1815101	1 51	, s	AUS13	BURY,	70:	218	04		
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08-06762 Anthony Savoy		State	or Print in Black of Maryland / De	epartm	ent of Hea	alth and N			pible. 200	08 3049	
		1- For State  Registrar9_16_08Amerro#20t  1. Decedent's Name (First Middle La	20c. PerFam. PG	Certific	ate of Dea	ath			g. No.	(a.t. (a	
Physici Medical Exam	an/	. Decodorit's Harrie (First, Wildlie, La	5()					<ol><li>Date of Death Month September</li></ol>		3. Time of Death 2102 hrs	
e and Exam		ANTHONY SAVOY,  4a. Facility Name (if not institution, gi	Ve street and number)		4b. City	, Town, or Loca	ation of Death	September	4c. County of Dea		
		2641 Shadyside Avenue	14.8		1 1	land			Prince Georg	je's	
Funeral		Social Security Number     6. S	Sex 7. Age (In	yrs. last bir			f Under 24Hrs.	8. Date of Birt		irthplace (State or	
Director		579-45 <b>-</b> 5099	M 2 F		Yrs. Mor	1 ' 1	Hours Min.	12/13/	2007	ignWashington country) DC	
		Usual Residence of Decedent				1.47.1_		112/13/	2007		
w any		10a. State 10b. County	10c.	City, Town	or Location					10d. Inside City Limits 1 X Yes 2 No	
rland -f sho once.	tor	Maryland Prince ( 10e. Street and Number	George's S	uitla				Tie			
Mary r 28a ed at	irec					Zip Code			g. Citizen of What Co		
th the	Funeral Director	2641 Shadyside A				20746	- 0-1-1-0 / 0-		nited Stat		
ath wi	ner	11. Marital Status  1 X Never Married 2 Marrie			If Yes, spe	cify Cuban, Me	exican, Puerto l	ecify Yes or No- Rican, etc.)	White, etc.	erican Indian, Black,	
ter de		3 Widowed 4 Divorce	1 Yes 2 X d If Yes, Give Year	No	1 Yes	2 X No sp	pecify:		Specify: B	ack	
urs af itural	d by	15. Decedent's Education (Specify of	or Dates:		Decedent's Usu	al Occupation (	(Give kind of w		16b. Kind of Busines:		
72 ho 72 ho n "na	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of w	vorking life. DO	NOT use retin	ed)			
vithin ene.	Completed	0						none		none	
21215-0036 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, Middle, Las						,	faiden Surname)		
127 Id be Id be Inarke	o Be	Anthony Maurice 19a. Informant's Name/Relationship (	2	10	h Mailing Addre			C. Joh	nson ber, City or Town, Sta	to Zin Code)	
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s, M and 2 fealth fcm 2 traur		Brittney C. Johns 20a. Method of Disposition	son / Mother	20b. Place	of Disposition (N	lame of cernete	ery,	Date	20c. Location - City	or Town, State	
IOFE ges 1 it of F it. If i		1 X Burial 2 Cremation 3		Moul	ne ordination	Cem.	9/13 م	3/2008	Washingto	on, D.C.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Memlen Hygiene. Important: I firm 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	-	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice	/: nsee	wasn					1 Homes, I		
Ba perm Depr Imp		Kitt a Xu	10 1 M1010	~						1and 20747	
Physician		23a. Par I. Enter the disease, or com	pligations that caused the d	eath. Do n						Approximate Interval	
/Medical	1	failure. List only one cause on e Immediate Cause (Final disease a	acn line. Multiple Gunshot W	ounds						Between Onset and Death	
xaminer		or condition resulting in death)	Due to (or as a consequen								
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d sit	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ice of):							
executed an and al - transi											
	gigi	UNPENDED	AMENDED								
Box 68760, the death certificate be execut the attending physician and red for use as the burial - tra	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy 2	Fetal deat	h 3 E	Ectopic pregnar	ncv	23d. Date of delive Month	ery Day Year	
Sox 687 death certifi e attending for use as t	icia	past 12 months?	4 Pregnant at time		p			,		,	
Bo e deat the at ed for	Phys	1 Yes 2 No 9 Unknow	9 Olikilowii								
.O. hat the ed by detach	by P	Part II. Other significant conditions	contributing to death but i	not resultin	g in the underlyi	ng cause given	in Part I.			to the cause of death?	
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ord w req	Bet							24a. Was a autops	sy prior to	autopsy findings available completion of cause of	
Reco	Completed							perform 1 <b>V</b> Yes 2			
al Fian: Jertific ctor, p	Be	25. Was case referred to medical examiner?					Death (Check o	nly one)			
Vit hysical this o		1 ✓ Yes 2 No	Hospital: 1 Inpatient 2		utpatient 3	DOA Othe			Residence 6 🗸 Oth	er: Scene	
ing P		27. Manner of Death  1 Natural 5 Panding	28a. Date of Injury (Month, Day, Year) Sep 3, 2008	I .	Time of Injury  ) hrs	28c. Injury at		28d. Describe h Subject shot	ow injury occurred		
Sior Vitend death ctor: y the	catic	2 Accident Pending	ion				2 V No			and Book Mark Street	
Division of Vital Records, P.O. Box 68760, spital or Attending Physician: The law requires that the death certificate b nors after death. After this certificate has been signed by the attending physiciale in by the funeral director, page 2 should be detached for use as the but	Certification:	3 Suicide 6 Could not determine			arm, street, facto	ry, office buildi		or Town, State)			
Division  Division  Hospital or Attend 24 hours after death. Funeral Director:		29a. Certifier	1 diking			ha sima dese			de Avenue, Suitland		
Division of Vital Records, P.O. Box 68760, within 24 houst after detail or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only Certifying Physic	ian: To the best of my known: T:On the basis of examinati								
To the within To the Comple	Ş.	29b. Signature and title of certifier	and manner stated.	-		9c. License nu			29d. Date signed (N		

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State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Russell Alexander MD.

O 2008

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

September 4, 2008

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra/MEND#23oper MD 9-9-2008, BMW, Moco Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 24, 10:20 A.M **Physician** Richard M. Swift 2008ª /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Chevy Chase Montgomery Manor Care 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1932 1 € M 2 🗆 F 75 Vrs Illinois 358-22-9893 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at Maryland Chevy Chase Montgomery 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 United States 8700 Jones Mill Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 'naturai", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7's Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any Injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George B. Swift Gladys Meyers ည 19a. Informant's Name/Relationship (Type. Print)

Hanning Schonwandt / Power Of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henning Schonwandt/ 3203 Parkview Road, Chevy Chase, MD 20815 Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place)
Georgetown University 20a. Method of Disposition 20c. Location - City or Town, State August 2008 24 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4√ Donation 5 ☐ Other (Specify) Medical Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 Stature o Funeral Service Licens Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rostate Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: Remove Item use 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 plonths? jo 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Yes 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2 No 1∐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 21 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To the funeral Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Funerail 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature a title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OB 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Drive

State

Registrar

Hwang,

2008

Leon C.

31. Date filed (Month, Day, Year) SEP 0 9

32 Registrar's Signature

Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month SEP **Physician** 9:00 P M 2008 DOROTHEA MOSHIER SIGMUND 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 8. Date of Birth Aug. 24, 1917 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. Pennsylvania 577-60-1944 1 □ M 2 💢 F 91 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show other traumatic event, the Medical Evaminar must be notified at 1 ☐ Yes 2 No North Bethesda Maryland Montgomery Be Completed by Funeral Director or 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 5550 Tuckerman Lane, #210 items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married ō, White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: 3 X Widowed 4 ☐ Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) United States Government Management Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Lilly Percy Moshier ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5924 Natasha Drive Berwyn Heights, Maryland 20740 Carol S. Remenick -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State permit. Pages
Department of
Important: If it
any injury or o Arlington National Cemetery 10/9/2008 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Bonard V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE CORONARY SYNDROME /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy Day Month for 5 ☐ Other (specify) ☐Yes 2 No P.O. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 3 Probably 4 Unknown 2X No 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2XINo 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2∏No Certification: To this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Division 5 Pending investigation 1 XNatural s after dee... ral Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide To the Hospital or Atte within 24 hours after de.
To the Funeral Directo completely filled in by the determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar

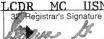
Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

ROBERT N. WALTER
31. Date filed (Month, Day, Year) SEP 0 9 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

11697 (HI)

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

CENTER

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2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#23a(d)perMD,9/15/08, BW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Yea KAMALA D. SHARMA SEPT 2008 10:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 🔽 F Director 212-11-8729 88 SEPT.16, 1919 INDIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exemiter must be redified at Director 1 TYYes 2 □ No MD. PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10g. Citizen of What Country? Funeral 7701 24th AVE 20783 INDIA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 1 ☐ Yes 2 ☐ No Specify. ASIAN INDIAN 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ DUNI CHAND SHARMA KHEMA DEVI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other trauonce. VIJAY SHARMA/SON 225 FOREST AVE., ROCKVILLE, MD. 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 9-10-2008 RIVERDALE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 207 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical use as the IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 Ectopic pregnancy in the past 12 mg Month Day Year 5 Other (specify) Tyes 2 No the 9 Unknown signed by t Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been . Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has page 2 2 □No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to redical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manne . Time of injury 28d. Describe how injury occurred Injury at Work? 1 atural 5 Pending investigation Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, pe o ۵. Division of Vital Records, or Attending Physician: Hospital

after death.

within 24 hours a

filled

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Medical

29a. Certifier

(Check only one)

29b. Signature and title.

and addre

Year)

2008

31. Date filed (Month, Day, SEP 0

the Maryland

death

filed within 72 hours after

Pages 1 and 2 should be

exect

Maryland 21215-0036

altimore,

State Registrar

DHMH 17 Rev 1/200

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month. Day, Year)